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* At the time this working paper was approved, Mr. Justice Linden was still Commission President, Judge Rivet was a Commissioner, Dr. Trevor-Deutsch was Project Co-ordinator and Madam Justice Picard and Professor Frémont had not yet joined the Commission.

Editor's Note

Note that the research in this working paper is generally current to July 1990, when the Commission adopted the recommendations set forth in chapter 5. The document has since received updating with some 1991 material.

In keeping with the proposal advanced in *Equality for All: Report of the Parliamentary Committee on Equality Rights*, we have conscientiously endeavoured to draft this working paper in gender-neutral language. In doing so, we have adhered to the standards and policies set forth in *Toward Equality: The Response to the Report of the Parliamentary Committee on Equality Rights* pertaining to the drafting of laws, since the Commission's mandate is to make proposals for modernizing Canada's federal laws.

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The very nature of the issues posed by revolutions in medicine and the biomedical technologies over the last quarter-century obliges the Commission to turn to diverse segments of society for assistance in its deliberations and analyses. Thus, in 1989, we expanded and formalized our consultative process on medico-legal issues. We established a multidisciplinary consultative committee to the Commission, the Advisory Group of Experts on Health Law. This document has had the benefit of their generous review and advice.

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The views expressed in this working paper are those of the Commission, and do not necessarily reflect those of Parliament, the Department of Justice or any of the individual consultants.

Introduction

Modern medicine has again begun challenging the law to rethink its views on the legal status of the human body in matters involving life and death. Ten years ago, the Law Reform Commission of Canada joined several public analysts in recommending new criteria for the determination of death.[1] Newer tools of medicine, such as mechanical respirators and circulators, had come to obscure the meaning and utility of the traditional heart-lung cessation criteria for death.

If a hospitalized patient could continue indefinitely on mechanical support, with no responsiveness and no brain functions, would the patient legally be dead or alive? The answer has become clearer, because the proposed brain-death criteria have become a customary standard for both modern medicine and law. Such legal reform reduces uncertainty and confusion. The certainty gives families and medical professionals a contemporary standard for responding to particular life-death scenarios. Transplanting organs from a recently deceased donor involves maintaining the dead body on artificial life support so that the donor's organs may be preserved until a recipient is ready. The clarity afforded by the new standard for death, then, has also facilitated organ procurement and transplantation.

In the decade since the Law Reform Commission's proposal, transplant and tissue replacement technology have come of age. Medical developments have revolutionized the therapeutic potential of transplanting human organs, tissues and cellular and genetic entities. New drugs and better established procedures have increased transplant recipients' survival rates; they have also helped move liver and heart transplants towards the standard medical treatment that kidney transplants have attained for years in Canadian society.

The quest of high-technology medicine to conquer disease and to extend life, however, has not been without its challenges. Surgeons speak of critical organ shortages. Waiting lists for eyes, kidneys and livers are the rule in transplant centres across the country. Waiting lists, professional frustration and the loss of lives that might have been saved, portray personal and societal dramas. Such results of apparent scarcity exert pressure on the existing organ procurement system, which is based on principles of autonomy, voluntarism, protecting bodily integrity and according respect to the dead and their next

1. Law Reform Commission of Canada [hereinafter LRC], *Criteria for the Determination of Death*, Report 15 (Ottawa: Supply and Services Canada, 1981).

of kin. The pressures exerted by scarcity prompt calls for reforms — reforms which might include measures that challenge the values and assumptions of the existing system.

So new questions are emerging. What legal reforms, if any, should be instituted to alleviate perceived tissue scarcity? Should the brain-death criteria be amended for babies who are born without most of the upper brain and usually die within seventy-two hours after birth, to facilitate organ procurement from them? Is the selling of bodily parts or substances an acceptable means of increasing the supply of blood, tissues and organs? Or, to discourage acts of medical and economic desperation and to preserve fundamental values, should some sales of bodily parts or substances be made criminal offences? Indeed, in response to increasing concerns about international trafficking in organs, the World Health Organization has urged the international community to take measures to prevent and discourage such transactions.[2] That organization has identified organ transplantation as a biomedical development that challenges the moral and legal integrity of the individual.[3]

If the answers to questions such as those posed above are not as clear as Canadian society would wish, they nevertheless appear likely to be scrutinized and debated with increasing frequency as medicine evolves ever new means of using the body for therapeutic purposes. The questions themselves are not without historical precedent, however. Two historical controversies suggest that the medical-legal issues presented by the apparent disequilibrium between the medical demand and societal supply of human tissue and bodily substances are not unique to the transplantation age.

The first controversy arose a century and a half ago. In the autumn of 1843, some two decades after McGill University established the first medical school in Canada, the Medical Board of Montreal petitioned the Legislative Assembly of the Province of Canada to pass an Anatomy Act. The petition was submitted after nightly episodes in which the securing, by medical school students, of dead bodies from Montreal graveyards had provoked public outcry and calls for solutions to such "gross indecencies."[4] A scarcity of human specimens had prompted medical students, and even anatomy professors, in other Canadian locales to resort to such measures for years.[5]

Accordingly, the petitioners sought an Anatomy Act to establish a regulated, legal system for supplying cadaver bodies for dissection and anatomical study in the medical schools. The absence of an existing system, they argued, hampered medical education and the practice of the healing arts, to the public detriment.[6] A regulated system of supply

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2. See 1989 World Health Organization [hereinafter WHO] Resolution, *infra*, note 1047, reproduced in part in appendix A, *infra* at 202-203.

3. WHO, *Health Aspects of Human Rights: With Special Reference to Developments in Biology and Medicine* (Geneva: The Organization, 1976).

4. See D.G. Lawrence, "'Resurrection' and Legislation or Body-Snatching in Relation to the Anatomy Act in the Province of Quebec" (1958) 32:5 Bull. Hist. Med. 408 at 411.

5. See Worthington, *infra*, note 809.

6. See Debates, *infra*, note 803 at 464-67.

would rid the community of grave-robbing, body-selling and like black market abuses. Opponents countered that a more appropriate source would be the bodies of criminals, that the proposed legislation would legalize a "traffic in corpses," and make public property of cadavers.[7] The debate resulted in passage of *An Act to regulate and facilitate the study of Anatomy*, in December 1843.[8] The Act adopted the principle that unclaimed bodies, publicly exposed or in such public institutions as hospitals, should be made available as anatomic subjects for the medical schools.

The bodily sales and bodily property language of over a century ago has been resurrected in a more modern controversy. It highlights issues surrounding the legal protection of patients and bodily integrity in a biotechnological age. In a recent case in the United States, a leukemia patient sued his doctor and a university hospital, claiming that without his knowledge or consent his pancreas cells were used to develop a therapeutically valuable "cell line."[9] The cell line has been used to make new drugs capable of controlling cancer, and is of such commercial value that the cell line has been patented. The patient claims a breach of consent, the taking of bodily property and a rightful share of the money generated by the patent.

No such cases have been reported in Canada. Nevertheless, the case illustrates the potential for disputes between the sources of human cells and tissues and those persons who acquire and use them. It suggests the unprecedented economic and commercial value that particular bodily substances and materials may attain, by virtue of new medical biotechnologies and the legal protection given to the commercial fruits of the technologies. The case would also seem to symbolize an important transitional era through which law and society have begun to journey. The era is characterized by a societal search to define the content of the legal regimes likely to govern tissue transfers and tissue replacement technologies into the twenty-first century.

It is the broader contexts of these tissue transfer and transplant issues that provoke the general question of whether the law is keeping pace with the modern medical demands for the human body. The 1843 debates on the *Anatomy Act* parallel concerns expressed today in debates over alternatives for increasing the supply of cadaver organs. Analysts again ask whether the law is hindering or properly regulating the supply of human tissues and bodily substances. Since the tissues in demand today are sought for therapeutic implantation or transfusion into the human body, safety concerns have also arisen. If legal reforms are in order, what rights, duties and balance of interests should be affirmed or changed?

In search of answers to such questions, we have examined the medical and legal aspects of procuring and transferring natural human tissues and bodily substances, relative to emerging tissue replacement technologies. Initial research made clear that answers to some of the difficult questions posed by modern developments likely depend on the ethical

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7. *Ibid.*
8. S. Prov. C. 1843, c. 5 [hereinafter *Anatomy Act*]. See chap. 3, section III.B(1), below.
9. See *Moore* (1990), *infra*, note 426.

implications of an increasing medical reductionism of the human body. If the facility by which medicine reduces the human body to its biological components for therapeutic benefit is boggling, it is partially so because it also touches basic social values and views on the uses of living and dead bodies. Medical science will continue to develop increasingly sophisticated means of converting formerly useless bodily parts and substances into modern therapeutic agents. This tendency and its full societal implications have persuaded us that critical to understanding the legal and medical view of the human body is an understanding of our evolving ethical outlook. Hence, from an historic perspective, the inquiry into these subject-matters traces the evolution of law on the human body, and its ethical underpinnings, as society has moved from the anatomical age of the nineteenth century into the transplantation and biotechnological ages of the twentieth century.

It is within these broader contexts that the Commission has undertaken this Working Paper. We have done so mindful of the important work done in the area by the federal-provincial-territorial transplant working groups[10] and provincial task forces[11] in the mid-1980s, the more recent law reform initiatives by the provinces and by the Uniform Law Conference of Canada,[12] as well as the pronouncements of international organizations and foreign jurisdictions.[13] Our work is intended to draw on and complement these contributions.

The following, then, is our initial analysis and views on major legal issues presented by human tissue procurement and transfer law in Canadian society. Chapter 1 discusses the medical need for and the supply of human tissue and bodily substances; emerging legal and ethical dilemmas provoked by demand and supply disequilibria are examined there as well. Chapter 2 is an analysis of the underlying ethical considerations of tissue procurement. Chapter 3 examines existing law on the human body through the lens of common, civil and criminal law. It looks at historical and current tissue procurement legislation and considers the human rights implications. Chapter 4 examines the leading legal approaches to tissue transfer issues in foreign jurisdictions, as well as legal issues presented by the international transfer of human therapeutic tissue and tissue replacement technology. Chapter 5 outlines arguments for and against major law reform options, proposes general principles and summarizes our recommendations.

Because fetal tissue and human gametes and embryos evoke special concerns, they generally are not treated in the present analysis. Nor are the critical questions concerning the allocation of scarce medical resources generally within the scope of the immediate inquiry. The focus here is on procurement and transfer issues.

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10. See *infra*, note 29.
11. See *infra*, notes 29 and 143.
12. See pages 130-136, below.
13. See chap. 4, below.

CHAPTER ONE

Modern Therapeutic Demand and Supply

The demand for and supply of human tissue and bodily substance result from several factors, including evolving medical needs and practice. This chapter examines the anatomical, medical and biotechnological demands as they relate to supplies from living and deceased donors, synthetic and artificial sources and tissue banks. The overview reveals vibrant tensions between evolving therapeutic needs and the accelerating ingenuity of medicine to remake the human body with tissue replacement technology. Leading non-medical determinants of supply and demand are identified, and ethical-legal questions that warrant closer examination in subsequent chapters are highlighted here. This chapter concludes by summarizing the major determinants in the supply-and-demand dynamic.

I. Medical Demand

Modern therapeutic demand for the human body reflects the need for and use of human tissue, bodily parts and bodily substances in medical education, research and treatment. The demand expresses the convergence of the anatomical, transplantation and biotechnological ages in current medical practice.

A. Anatomical Demand

A knowledge of human anatomy is responsible for much of our understanding of illness and the treatment of disease. The word "anatomy" derives from Greek root words meaning "to cut up or dissect"; hence, human anatomy classically refers to studying the structure and function of the body through dissection.[14]

While dissection and anatomical studies are more than 4,000 years old, modern anatomy owes its origins to the rise of eminent faculties of medicine in thirteenth-century

14. See Doris Burda Wilson and Wilfred J. Wilson, *Human Anatomy*, 2d ed. (New York: Oxford University Press, 1983) at 3.

Europe.[15] The charters of some universities[16] founded in the Renaissance even incorporated provisions authorizing the use of cadavers for medical instruction at a time when superstition and some religious sentiment[17] opposed, if not condemned, post-mortem involvement with the human body. Practical necessity also helped modify attitudes, as perhaps illustrated by the need to determine the cause of death by dissecting the bodies of victims of the Black Plague that swept late medieval Europe.[18] The sixteenth-century publication of Andreas Vesalius' *De Humani Corporis Fabrica*, the "treatise on which modern anatomy has been founded,"[19] helped standardize and establish dissection as a basic course in university medical schools. That work prompted the then Holy Roman Emperor, Charles V, to place the question of anatomical study before a theological council. The council ruled favourably and "thereby gave final assurance of the uninterrupted use of human dissection in advancing anatomy and pathology."[20] Thus, by the nineteenth century, medical students were even required to have dissected the human body before graduation.[21]

Today, human anatomy remains integral to the medical educational curricula of the twenty-two medical schools in Canada. It is a basic requirement for students of medicine, nursing, physiotherapy, dentistry and occupational therapy. Part of the simple logic behind this medical school requirement has long been that if the structure and function of the human body are not learned in the anatomy or dissecting laboratory, they will be learned by "mangling the living" in the practice of medicine.[22] In other words, a knowledge of human tissues, organs and major body systems is deemed critical to understanding, preventing and treating illness.

Acquiring such knowledge has long required human bodies as anatomical specimens, as the debate surrounding passage of the Canadian *Anatomy Act* of 1843 demonstrates. The research needs of modern medical schools have added to the demand. Today, over 600 cadaver anatomy specimens are needed annually for medical school education and teaching.[23] International pioneering work in progress on an electronic cadaver — computer-based, interactive, simulated dissection — may help to meet future anatomical demand.[24]

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15. See T.V.N. Persaud, *Early History of Human Anatomy* (Springfield, Ill.: Charles Thomas, 1984) at 77-88. See generally Arthur M. Lassek, *Human Dissection: Its Drama and Struggle* (Springfield, Ill.: Charles Thomas, 1958).

16. See Sonoma Cooper, "The Medical School of Montpellier in the Fourteenth Century" (1930) 2 (N.S.) Annals Med. Hist. 164 at 178 (describing The Medical School of Montpellier Statutes of 1340).

17. See Jack Kevorkian, *The Story of Dissection* (New York: Philosophical Library, 1959) at 39-41. But see James J. Walsh, "The Popes and the History of Anatomy" (1904) Med. Libr. and Hist. J. 10.

18. Kevorkian, *supra*, note 17 at 189.

19. James Moores Ball, *The Sack-'Em-Up Men: An Account of the Rise and Fall of the Modern Resurrectionists* (London: Oliver and Boyd, 1928) at 40.

20. Kevorkian, *supra*, note 17 at 50.

21. See chap. 3, section III.B(1), below.

22. See U.K., *Report from the Select Committee on Anatomy* (London, 1829) at 13 [hereinafter *Select Committee*].

23. Based on an informal 1989 LRC survey of provincial coroners and medical school anatomy chairpersons. Demand for most of the specimens comes from some dozen medical schools in Quebec and Ontario.

24. See Lawrence K. Altman, "Computers Create Electronic 'Cadavers' for Anatomy Lessons" *New York Times* (6 September 1988) C3.

B. Transplantation Demand

Routine tissue transplants are twentieth-century phenomena which have evolved from the simple to the complex. For decades, blood, cornea, bone marrow and skin transplants have been routine treatment for select medical conditions. Some complexity has also been mastered. Over the last fifteen years, organ transplants have played an increasing role in the treatment of disease. Indeed, as Canadian society nears the fourth decade of vital organ transplant technology, transplantation is now considered the treatment of choice for selected patients with end-stage kidney, heart or liver failure.[25] Before such developments, patients afflicted with the conditions that transplants now treat were condemned to disability, prolonged illness, reliance on artificial organs or death.

The following examination of major tissue transplant technologies portrays societal demand for bodily tissue as a partial result of the evolution of particular transplant procedures in medical treatment. The details of each transplant story may prove dramatic because certain transplants, especially organs, sometimes involve life and death. But in each story, important parts of a generality are portrayed, because human tissue transplants tend to be governed by shared principles and challenges.

Successful transplants depend, for example, on an intricate understanding of the tissue involved, skilled transplant personnel and facilities, an accurate matching of the donor and recipient tissues, the perfection of transplant procedures, maximized tissue preservation methods, effective patient selection and the management of tissue rejection. As such, the surmounting of a basic technical impediment may benefit a range of tissue transplant patients. The point is illustrated by the revolutionary impact which the drug cyclosporine had on reducing tissue rejection and dramatically boosting success rates for liver and heart transplantations in the 1980s.[26] Early results indicate that similar new drugs may further advance success rates in the 1990s.[27]

As technical impediments are overcome, the judgment as to whether a transplant procedure is considered experimental or routine therapy is guided by such medical factors as survival rates, the pros and cons of alternative treatments and the general consensus on and diffusion of the technology. As transplant procedures move from the experimental to the routine, demand for a procedure may increase. Thus, a 1984 Canadian tissue procurement conference concluded that "[t]oday, the significant factor limiting the number of transplants done is the available supply of organs and tissues."[28] That conclusion echoes the unanimous findings of federal and provincial task forces and commentators

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25. David Grant et al., "Experience of a Canadian Multi-Organ Transplant Service" (1986) 135:3 C.M.A.J. 197.

26. See generally "Proceedings of the Second International Congress on Cyclosporine: Therapeutic Use in Transplantation" (1988) 20:3 (Supp. 3) Transplant. Proc.

27. See Thomas E. Starzl et al., "Kidney Transplantation under FK 506" (1990) 264:1 JAMA 63.

28. Health and Welfare Canada [hereinafter HWC], *Ways and Means to Enhance Human Organ and Tissue Procurement and Exchange in Canada* (Ottawa: Supply and Services Canada, 1985) at 1.

that have examined the issue.[29] Five years later, the statement remains accurate. The statistics in table 1 outline the number of procedures performed and numbers of people on transplant waiting lists as some indicia of general demand and supply in Canada. The procedures performed and numbers on waiting lists are highest for two of the older tissue transplant procedures, corneal and kidney transplantation. The details behind these and other tissue transplants provide insights into the demand for and supply of human tissue.

(1) Blood Products and Vessels

Blood is a tissue that consists of a variety of cells suspended in a fluid medium called plasma.[30] Modern knowledge of the circulatory system emerged in the seventeenth century, and unsuccessful blood transfusions were attempted at about the same time.[31] The lack of success likely resulted from recipients receiving incompatible blood, which may cause minor to severe reactions.[32] It was not until the discovery of the four major blood groups (A, B, AB and O) in 1901, and the later refinement of blood-matching procedures, that successful blood transfusions were routinely performed.[33] Blood was one of the first tissues to be successfully transferred between human beings for treatment.

Further understanding of the properties of blood and the development of preservation methods made blood banking a possibility in the decade before World War II.[34] During World War II, the Canadian Red Cross Society assumed the major responsibility for the collection and distribution of blood. After the war, Canada designated that organization as the entity charged with collecting and distributing blood and blood products nationally.[35]

Today, blood transfusion is considered the "foundation of modern medicine" and has been "regarded as the first successful organ transplant."[36] The Canadian Red Cross Society operates seventeen centres across Canada through which it collects, screens and

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29. Compare "Report of the Working Group on Vital Organ Transplant Centres to the Deputy Ministers of Health" (September 1985) [unpublished] at 17-19 [hereinafter FEDS]; U.S. Department of Health and Human Services, Public Health Service, Task Force on Organ Transplantation, *Organ Transplantation: Issues and Recommendations* (Washington, D.C.: U.S. Government Printing Office, 1986) at 27 (need for organs far exceeds supply) [hereinafter USTF]. See Task Force on Organ Donation, *Organ Donation in the Eighties: The Minister's Task Force on Kidney Donation* (Toronto: The Task Force, 1985) [hereinafter ONT]. See also Roger W. Evans et al., "Donor Availability as the Primary Determinant of the Future of Heart Transplantation" (1986) 255:14 JAMA 1892.

30. Paul R. Wheater, H. George Burkitt and G. Daniels, *Functional Histology*, 2d ed. (Edinburgh: Churchill Livingstone, 1987) at 36.

31. See William Harvey, *On the Motion of the Heart and Blood in Animals*, 1628 (reprint Chicago: Gateway, 1962).

32. See Gilbert M. Clark, ed., *Legal Issues in Transfusion Medicine* (Arlington, VA: American Association of Blood Banks, 1986) at 191.

33. Harvey G. Klein, "Transfusion Medicine: The Revolution of a New Discipline" (1987) 258:15 JAMA 2108.

34. *Ibid.*

35. Report of the Steering Committee to the Canadian Blood Committee, *Study on Plasma Fractionation in Canada* (Ottawa: The Committee, 1988) at 13 [hereinafter CBC].

36. *Ibid.*

TABLE 1. Select Canadian "Tissue" Transplant Statistics*

Tissue or Organ	Maximum Preservation Time	Recipient Survival Rates	Centres	Number of Procedures Performed per Year						Waiting List					Cost per Case°
				1989	1988	1987	1986	1985	1981	12/89	12/88	12/87	12/86	12/85	
Milk	(a) 1–2 days (b) 6 months frozen	—	19	—	—	—	—	—	—	—	—	—	—	—	—
Blood	(a) 35 days□ (b) 10 years frozen•	—	17•	—	—	—	—	—	—	—	—	—	—	—	—
Bone Marrow	10+ years frozen♦	—	9	—	167	144	127	129	60	—	—	—	—	—	—
Corneas	3–4 days	—	10	2,412	2,236	1,956	1,897	981	—	1,301	1,288	922	1,234	1,059	$80,000
Kidneys	(a) 24–72 hours (b) 72 hours in w/UW solution#	93–97% (1 year) 82–91% (5 years)	25	858	902	826	871	737	482	1,338	1,168	1,192	939	1,027	$50,000
Lungs	—	53.7% (1 year)	6	11 S 8 D	8 S 8 D	6 S 6 D	1 S 1 D	2 S	0	13 S 8 D	11 S 13 D	5 S 2 D	5 S 3 D	2 S	—
Livers	(a) 9 hours (b) 24–34 hours in w/UW solutions#	70% (1 year) 60% (5 years)	10	120 A 34 C	97 A 35 C	82 A	66 A	36 A	1 A	48 A 10 C	28 A 4 C	12 A 11 C	15 A U C	34 A U C	$84,000
Hearts	4–8 hours	80% (1 year) 70% (5 years)	11	158	185	131	123	42	1	80	52	51	50	36	$83,000

Legend: A = adult; C = child; D = double; S = single; U = unavailable.

*Unless otherwise noted, the sources for these statistics are: Canadian Organ Replacement Register, *1988 Report* and *1989 Report* (Don Mills, Ont.: Hospital Medical Records Institute, 1990 and 1991) and Health and Welfare Canada.

°Patrick Sullivan, "Report Raises Questions about Cost of Organ Transplantation" (1988) 139:5 C.M.A.J. 433.

□See Canadian Pediatric Society, Nutrition Committee, "Statement on Human Milk Banking" (1985) 132:7 C.M.A.J. 750.

□Canadian Red Cross Society [hereinafter CRCS], *Clinical Guide to Transfusion: Products and Practices*, 2d ed. (Ottawa: The Society, 1987) at 29-30.

•See CRCS, *Blood Services Statistical Report 1988-89* (Ottawa: The Society, 1989) at 12, 18.

♦Personal communication with the Canadian Bone Marrow Transplant Group.

#HWC, "Symposium: Organ Transplantation in Canada Today" (1987) 20:1 Annals RCPSC 57 at 58.

#See Satoru Todo et al., "Extended Preservation of Human Liver Grafts with UW Solution" (1989) 261:5 JAMA 711; Folkert O. Belzer and James H. Southard, "Principles of Solid Organ Preservation by Cold Storage" (1988) 45:4 Transplant. 673 at 675.

distributes roughly one million units of blood annually.[37] Donated blood is generally separated into red blood cells (45 per cent) and plasma (55 per cent). Red blood cells and plasma may then be further processed into the blood product derivatives that help provide lifelines into the modern hospital. Accident victims and patients undergoing major surgery, for example, require blood replenishment to prevent life-threatening shock. Similarly, severe burn victims and hemophiliacs, who lack the normal clotting factors that stop bleeding, routinely depend on plasma derivatives for treatment.

Such therapeutic needs create a demand for blood products. Since 1981 the federal, provincial and territorial governments have worked through the Canadian Blood Committee to develop a national blood policy. The national principles on which the Committee had operated for years were recently revised to emphasize voluntarism, gratuity or non-payment, national self-sufficiency, blood product safety, adequacy and security of supply, a national versus a regional blood system, cost-effectiveness and cost-efficiency.[38] Despite occasional acute local blood shortages and a chronic shortage of plasma for fractionation, the Canadian blood system is regarded in the international community as a voluntary system which generally satisfies Canada's national blood product needs.[39]

Beyond the demand for blood products themselves, modern medical needs have helped to create a demand for the conduits through which blood flows in the human body. For example, processed human umbilical cords are implanted as veins in the surgical repair of severely injured limbs.[40]

(2) Bone Marrow Transplants

Bone marrow is the soft tissue found in the inner cavity of bones. It helps to produce red blood cells, which carry oxygen, white blood cells, which attack foreign and infectious substances, and platelets, which prevent bleeding. Bone marrow transplants have been used to treat diseases such as severe aplastic anemia and leukemia for some twenty-five years.[41]

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37. See CRCS, *Blood Services Statistical Report 1988-89* (Ottawa: The Society, 1989) at 6-8, 10.

38. Effective 1991, a newly created non-profit corporate entity, called the Canadian Blood Agency, will carry forward the mission, mandate and revised principles of the CBC. In essence, the revised principles expand on and clarify the original four principles of voluntarism, gratuity, self-sufficiency and non-profit, with the exception that the latter is replaced with cost-effectiveness/cost-efficiency — a principle which may allow for limited for-profit mechanisms to help satisfy the supply and self-sufficiency principles of the national blood system. See *Annual Report of the Canadian Blood Committee to the Provincial-Territorial Conference of Ministers of Health* (1989). See also CBC, *supra*, note 35 at 19-22. Compare World Health Organization and League of Red Cross Societies, "Final Recommendations of the Meeting on the Utilization and Supply of Human Blood and Blood Products (1975)" in Piet J. Hagen, *Blood: Gift or Merchandise* (New York: Alan R. Liss, 1982) 200.

39. See U.S. Congress, Office of Technology Assessment [hereinafter OTA], *Blood Policy & Technology* (Washington, D.C.: OTA, 1985) at 177. See also text accompanying notes 202-206, below.

40. See James H. Thomas et al., "Vascular Graft Selection" (1988) 68:4 Surg. Clin. North Am. 865; Jens H. Eickhoff et al., "Four Years' Results of a Prospective, Randomized Clinical Trial Comparing Polytetrafluoroethylene and Modified Human Umbilical Vein for Below-Knee Femoropopliteal Bypass" (1987) 6:5 J. Vasc. Surg. 506.

41. Noël A. Buskard, "Bone Marrow Transplantation: 25 Years of Progress" (1988) 21:7 Annals RCPSC 487. See also Noël A. Buskard, "Future Directions of Bone Marrow Transplantation" (1987) 137:4 C.M.A.J. 277.

With long-term survival rates of roughly 50 per cent, bone marrow transplantation is considered the treatment choice for severe aplastic anemia, for example.[42] Aplastic anemia is a blood disorder characterized by a persistently subnormal level of red blood cells. In untreated cases, 80 per cent of its victims are dead within six months after diagnosis; blood transfusions and other forms of therapy yield long-term survival rates of only about 20 per cent.[43] Similarly, bone marrow transplantation offers patients afflicted with leukemia, a cancer of the white blood cells, a better chance of long-term survival than does conventional treatment of the disease by chemotherapy.[44] Indeed, recent reports indicate that 50 to 80 per cent of acute leukemia patients who receive early bone marrow transplants have had prolonged disease-free survival.[45] The treatments appear to be cost-effective as well.[46]

A want of suitably matched donors limits the number of bone marrow transplant treatments currently performed at nine Canadian bone marrow transplant centres.[47] Many candidates for bone marrow transplant depend on donors who are related to them, such as siblings, because such donors tend to be more tissue-compatible, and this reduces the likelihood of rejection. A French and American team recently reported the successful use of frozen umbilical-cord blood from a newborn infant for transplant two weeks later into her five-year-old brother, who was afflicted with a disorder normally treated by bone marrow transplant.[48] As these alternative and customary technologies continue to develop, "[a]pproximately two-thirds of patients who may be eligible for an allogeneic (from an unrelated or related donor) bone marrow transplant do not receive one because of the lack of a compatible donor."[49] If those patients could be matched, the estimated 200 bone marrow transplants annually performed in Canada might double or triple.[50] Accordingly, the Canadian Red Cross recently established a national registry to increase the bone marrow transplant donor pool of unrelated Canadians.[51]

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42. Lawrence D. Grouse and Roxanne K. Young, "Bone Marrow Transplantation: A Lifesaving Applied Art" (1983) 249:18 JAMA 2528 at 2529.

43. Robert Dinsmore and Richard J. O'Reilly, "Bone Marrow Transplantation: Current Status" (1982) 12 Pathobiology Annual 213 at 214.

44. Michael Barnett, Allen Eaves and Gordon Phillips, "An Overview of Bone Marrow Transplantation for Chronic Myeloid Leukemia" (1990) 143:3 C.M.A.J. 187 at 188-89. See also Buskard (1988), *supra*, note 41 at 488.

45. See Gail Rock et al., "Registry of Unrelated Bone Marrow Donors" (1987) 137:3 C.M.A.J. 294 at 295.

46. See FEDS, *supra*, note 29 at 53. See also OTA, *The Cost Effectiveness of Bone Marrow Transplant Therapy and Its Policy Implications* (Washington, D.C.: U.S. Government Printing Office, 1981).

47. For projections on the number of centres 1985-90, see FEDS, *supra*, note 29 at 100.

48. Eliane Gluckman et al., "Hematopoietic Reconstitution in a Patient with Fanconi's Anemia by Means of Umbilical-Cord Blood from an HLA-Identical Sibling" (1989) 321:17 N. Engl. J. Med. 1174. See also Jean-Yves Nau, "Les cordons de la vie" *Le Monde* (7 December 1989) 19.

49. Buskard (1988), *supra*, note 41 at 491.

50. See CRCS and Canadian Co-operative Bone Marrow Transplant Study Group, *Proposal to Develop and Maintain a Canadian Registry of Voluntary Donors of Bone Marrow* (Ottawa: The Society, 1988).

51. See Noël A. Buskard, "A Register of Life: The First Year of the Unrelated Bone Marrow Donor Registry" (1989) 141:6 C.M.A.J. 600. See also text accompanying note 187, below.

Increased use of autologous bone marrow transplants (ABMT) may complement efforts to meet the demand for bone marrow transplants. ABMT involves procuring the patient's own bone marrow and preserving or freezing[52] it for later reinfusion into the patient after intensive chemotherapy.[53] While ABMT generally avoids incompatibilities and disease transmission between the donor and the recipient, there is concern that use of the patient's own bone marrow risks reintroducing the patient's disease.[54] Nonetheless, recent reports of successful ABMTs world-wide suggest that the procedure may be more widely used in the future.[55]

(3) Cornea Transplants

The cornea is the outer transparent window covering the eye. Cornea transplants, or keratoplasty, seek to replace corneas so severely scarred or clouded by disease or accident that impaired vision or blindness results. Experimental transplants undertaken in the nineteenth century led to the first successful corneal transplantation in Europe in 1906.[56] Still, "[t]he modern era of keratoplasty began in the 1950s with the advent of improved surgical techniques and fine sutures, . . . improved eye-banking methods, and the use of anti-inflammatory drugs to control graft rejection."[57]

Today, corneal grafting is the most frequently performed surgical tissue transplant in North America with a success rate of 90 per cent.[58] A total of 2,412 cornea transplants were performed in Canada in 1989.[59] Yet demand for the procedure exceeds the available supply of tissue. In 1989, 1,301 patients remained on active waiting lists for cornea transplants at the more than ten centres that performed the operation in Canada during that year.[60]

(4) Kidney Transplants

The first successful kidney transplant, between identical twins in Boston in 1954, ushered in the age of vital organ transplantation.[61] The procedure was first replicated in

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52. Bone marrow may be frozen for up to 13 years. U.S. Department of Health and Human Services, Public Health Service, National Center for Health Services Research and Health Care Technology Assessment, *Reassessment of Autologous Bone Marrow Transplantation* (Washington, D.C.: U.S. Government Printing Office, 1988) at 2.

53. See *ibid.* at 1.

54. *Ibid.* at 12.

55. See *ibid.* at 3-12.

56. Council on Scientific Affairs, American Medical Association, "Report of the Organ Transplant Panel: Corneal Transplantation" (1988) 259:5 JAMA 719.

57. *Ibid.*

58. *Ibid.* at 719, 721.

59. Communication with HWC, and communication with the Canadian Ophthalmological Society Committee on Eye Banks, Subcommittee on Administrative Co-ordinators.

60. *Ibid.*

61. See Joseph E. Murray and J. Hartwell Harrison, "Surgical Management of Fifty Patients with Kidney Transplants Including Eighteen Pairs of Twins" (1963) 105 Am. J. Sur. 205.

Canada at a Montreal hospital in 1958.[62] Improved surgical techniques and drugs to fight organ rejection eventually enabled Montreal surgeons to transplant kidneys between non-related persons in 1963.[63]

As the oldest solid organ transplant procedure, kidney transplant today defines the prototype of vital organ transplantation. It is the most frequently performed vital organ transplant procedure both in Canada and in the world. Canadian surgeons performed approximately three times as many kidney transplants in 1989 as heart and liver transplants.[64] Some 90 per cent of kidney recipients survive one year, depending on the source of the organ and the tissue rejection therapy used.[65] For those patients who may be candidates for both transplantation and the artificial kidney, the comparable survival rates, lower cost and better quality of life attributed to kidney transplants have generally made it the treatment of choice for irreversible kidney failure.[66] As with cornea transplants, demand for the procedure greatly exceeds supply. The shortage of donated kidneys meant that 1,338 patients awaited kidney transplants in twenty-five centres across Canada at the end of 1989.[67]

(5) Heart Transplants

In 1967, South African surgeon Christian Barnard drew international attention by performing the first human heart transplant. The patient survived eighteen days.[68] Over the next fifteen months the number of heart transplants world-wide soared; surgeons performed the first Canadian heart transplant — the eighteenth in the world — at the Montreal Heart Institute in 1968.[69] Poor survival rates, however, soon dampened initial enthusiasm. By the mid-1970s, few centres in the world continued to perform what was generally considered an experimental procedure.

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62. Mae Cox, *Human Transplants in Canada* (Edmonton: Human Parts Banks of Canada, 1978) at 17.

63. *Ibid.* at 18.

64. See table 1, *supra* at 9.

65. *Ibid.* Compare FEDS, *supra*, note 29 at 23; P.A. Keown and C.R. Stiller, "Kidney Transplantation" (1986) 66:3 Surg. Clin. North Am. 517 at 534; and U.S. Department of Health and Human Services, *Report on the Scientific and Clinical Status of Organ Transplantation* (Washington, D.C.: U.S. Government Printing Office, 1988) at 16.

66. Compare Roger W. Evans et al., "The Quality of Life of Patients with End-Stage Renal Disease" (1985) 312:9 N. Engl. J. Med. 553 and Roberta G. Simmons, Linda Abress and Carol Anderson, "Rehabilitation after Kidney Transplantation" in G. James Cerilli, ed., *Organ Transplantation and Replacement* (Philadelphia: J.B. Lippincott, 1988) 481 at 488.

67. Canadian Organ Replacement Register [hereinafter CORR], *1989 Report* (Don Mills, Ont.: Hospital Medical Records Institute, 1991) at 103, 111.

68. "Cardiac Transplantation" (1967) 4 Brit. Med. J. 757. For critical discussion of the informed-consent dialogue in this first transplant, see Jay Katz, *The Silent World of Doctor and Patient* (New York: Free Press, 1984).

69. Cox, *supra*, note 62 at 46-47.

In the 1980s, refined and standardized surgical techniques, improved patient selection and clinical management and anti-rejection drugs combined to boost survival rates. The use of the anti-rejection drug, cyclosporine, for example, increased immediate survival rates by 10 to 15 per cent.[70] Today, "[e]ighty percent of all heart transplant recipients now survive at least one year, and 50 per cent will survive 5 years."[71] The improved survival rates have helped move heart transplants from being regarded as experimental procedures towards acceptance as effective therapy for end-stage heart disease.[72]

The advances in heart transplantation have also led to broader diffusion of and demand for the technology. The number of transplants has increased threefold since some fifty were performed in 1985.[73] By the end of 1989, eighty patients were reported on waiting lists for heart transplants at eight Canadian centres.[74]

(6) Liver Transplants

In 1963, Dr. Thomas Starzl attempted the first human liver transplant in Denver, Colorado.[75] The first Canadian procedure was performed in Calgary eleven years later.[76] The transplants are designed to replace livers damaged by such conditions as genetic disorders, cancer and cirrhosis.[77] Unfortunately, fewer than 30 per cent of the early liver transplant patients survived a year, the low survival rate being due to rejection, uncontrolled bleeding, infections and technical complications.[78]

Medical advances again overcame initially poor results, however. Patient management and surgical techniques improved. The advent of the anti-rejection drug cyclosporine in the early 1980s helped double and triple one- and five-year survival rates.[79] Today, depending on the specific condition being treated by the liver transplant, "[s]urvival rates are ... 70% or more."[80] As with heart and kidney transplants, improved success rates

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70. USTF, *supra*, note 29 at 18 n. 4.

71. Evans et al., *supra*, note 29 at 1892.

72. Compare FEDS, *supra*, note 29 at 19 and U.S. Department of Health and Human Services, *supra*, note 65 at 23.

73. See CORR, *supra*, note 67 at 148.

74. As of December 1989. Communication with HWC, *supra*, note 59.

75. Thomas E. Starzl et al., "Evolution of Liver Transplantation" (1982) 2:5 Hepatology 614.

76. Cox, *supra*, note 62 at 47.

77. Thomas E. Starzl et al., "Liver Transplantation" (1989) 321:15 N. Engl. J. Med. 1014 at 1015.

78. William J. Wall, "Liver Transplantation: Current Concepts" (1988) 139:1 C.M.A.J. 21.

79. See Robert D. Gordon et al., "Indications for Liver Transplantation in the Cyclosporine Era" (1986) 66:3 Surg. Clinics North Am. 541 at 542-43.

80. Wall, *supra*, note 78 at 21. See also U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research, *Health Technology Assessment Reports, 1990: Assessment of Liver Transplantation* (Rockville, Md.: U.S. Department of Health and Human Services, 1990) [hereinafter *Liver Assessment*].

have increased the diffusion of and demand for the technology. Nearly twice as many adult liver transplants were performed in Canada in 1988 than were performed three years earlier.[81] By the end of 1989, forty-eight adults awaited donated livers at transplantation centres in Canada.[82]

Pediatric liver transplants are an even more recent development. Most children who are liver transplant candidates suffer from a birth defect known as biliary atresia, which is the blockage or underdevelopment of the bile duct. The bile duct transports bile from the liver to the small intestine. Duct blockage may cause jaundice or eventually lead to cirrhosis and death. While conventional surgery helps some children, "over half . . . will die within the first two to three years of life."[83] Because no Canadian centre performed liver transplants on children before 1985, pediatricians were obliged to make referrals to centres in the United States. By contrast, in 1989, Canadian surgeons performed thirty-four pediatric liver transplants; ten children remained on active waiting lists at the end of that year.[84] It remains to be seen whether a new experimental procedure may one day ease the demand for cadaveric livers for children. The new procedure involves transplanting part of the liver from a living adult donor into a child recipient, whereafter the adult donor's liver regenerates within a month and the child's new partial liver develops as the child grows.[85]

(7) Other Vital Organ Transplants

The demand for and performance of pancreatic, intestinal, lung, and heart-lung transplants are relatively modest, in part, because these newer procedures remain largely experimental.[86] For example, a Toronto team performed the first successful single and double lung transplant in the world only in 1983 and 1986 respectively.[87] Ontario surgeons performed the first successful small bowel transplant in 1989.[88] If such transplant procedures advance beyond experimental stages into established treatment modalities, the demand for them is likely to expand.[89]

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81. 97 v. 36. See table 1, *supra* at 9.

82. Communication with HWC, *supra*, note 59.

83. Diana Swift, "Scaled-Down Adult Livers Offer Transplant Hope to Newborns" *The Medical Post* (25 April 1989) 11.

84. Communication with HWC, *supra*, note 59.

85. See Russell W. Strong et al., "Successful Liver Transplantation from a Living Donor to Her Son" (1990) 322:21 N. Engl. J. Med. 1505; Gina Kolata, "Surgeons Complete Historic Transplant" *New York Times* (28 November 1989) C10.

86. See U.S. Department of Health and Human Services, *supra*, note 65 at 9.

87. See "CF Patient's Double Lung Transplant a First" (1988) 55:6 Ontario Med. Rev. 49; and R.F. Grossman et al., "Results of Single-Lung Transplantation for Bilateral Pulmonary Fibrosis" (1990) 322:11 N. Engl. J. Med. 727.

88. Cameron Johnston, "Canadian Surgeons Lay Claim to World's First Successful Bowel Transplant" (1989) 141:2 C.M.A.J. 156.

89. See FEDS, *supra*, note 29 at 36-38.

C. Biotechnological Demand

The onset of the biotechnological age has created new uses, demand and treatments of, and new conflicts[90] over, the human body. An American report recently identified over 100 therapeutic products under development by the biotechnology industry, "many, but not all" of which are derived from human cells or tissue.[91] Biotechnological advances hold the promise of enabling scientists to derive safe, generous quantities of pituitary and pancreatic extract, other hormones and blood-clotting factors from human tissues that for millennia had relatively little therapeutic value.

A contraction of "biological technology," the word biotechnology came into use following quantum developments in the science of manipulating cells and genetic material in the mid-1970s.[92] Cell fusion, cell culture and recombinant DNA (rDNA) are three major technologies that have proven instrumental to biotechnological applications in medicine. Recombinant technology involves the genetic engineering of deoxyribonucleic acid (DNA), the basic storage molecule for genetic information in the cell; DNA contains programmed instructions that effectively define cell components and how they are to be made.[93] In gene cloning, the recombinant DNA process, portions of DNA from one cell are isolated and transferred into another, so that the recipient cell may produce and express the genetic make-up of the original cell as it grows.[94]

Cell fusion and cell culture technologies also aim at manipulated cell growth. Cell fusion technology, which involves the fusion of cells from different species, may yield immortal hybrid cells called hybridomas.[95] To secure large numbers of genetically different cells that may be fused, biotechnologists have refined the age-old process of cell culture technology — that is, deliberately culturing living cells as has been traditionally done in cheese and yogurt making. The modern application lies in cultivating tissue-derived cells into an indefinitely replicating growth known as a cell line.[96]

While translating these technologies into therapeutic products may be a formidable undertaking, some companies have successfully moved the fruits of biotechnological research from the laboratory into the hospital. Already, genetically engineered hepatitis B vaccines, insulin and the anti-cancer agent interferon have been licensed by federal authorities in Canada.[97] Vaccines derived from rDNA for polio and sexually transmitted

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90. See chap. 3, below.

91. OTA, *New Developments in Biotechnology: Ownership of Human Tissues and Cells*, paper prepared by Gladys B. White et al. (Washington, D.C.: U.S. Government Printing Office, 1987) at 56-59 [hereinafter White].

92. A. Crafts-Lighty, *Information Sources in Biotechnology* (New York: Nature Press, 1983) at 1.

93. White, *supra*, note 91 at 41.

94. Beak Consultants, *Regulatory Policy Options for Canadian Biotechnology* (Mississauga, Ont.: Beak Consultants, 1987) at 1.1.

95. White, *supra*, note 91 at 5.

96. *Ibid.* at 33.

97. Communication with Drugs Directorate, HWC. See also OTA, *Commercial Biotechnology: An International Analysis* (Washington, D.C.: OTA, 1984) c. 5 at 119.

diseases are being developed.[98] DNA- and cell-fusion-derived growth factors have been in use in clinical trials as new bone marrow transplant technologies.[99] Recombinant Factor VIII for hemophiliacs is expected to receive federal licensure in 1991-92.

Indeed, the development of one particular genetically engineered product, human growth hormone, illustrates the impact biotechnology may have on medicine and law. Hormones are produced in such small quantities in the human body that extracting them from human organs either requires mass quantities of the tissues or is simply not feasible.[100] The extraction of insulin from human cadaveric pancreatic cells, for example, has generally not been undertaken because the concentrations of hormones are so small. Diabetes patients have thus traditionally relied on insulin extracted from the pancreases of pigs or sheep, which has occasionally had undesirable health effects on human beings.[101]

In contrast, human growth hormone has traditionally been obtained from human pituitary cells. It is used to treat dwarfism, which results from the underproduction of pituitary gland hormones. For years, Canada has relied on a national program involving the procurement of cadaver pituitaries, their pulverization and the extraction and purification of growth hormone, to treat hundreds of children.[102] An obviously important factor in the supply of therapeutic growth hormone in such circumstances is the "availability of human pituitaries."[103] Hence, several provinces have enacted presumed-consent laws to facilitate the procurement of pituitary glands from cadavers for the program.[104]

Recently, the national program underwent a basic change. Between 1985 and 1987, most Canadian pediatricians switched from cadaver-derived to rDNA-derived human growth hormone as a result of two events: first, a concern in the international medical community that recent deaths of human growth hormone patients might be attributable to their having received cadaver-derived, infected human growth hormone; secondly, the start of clinical trials to test the efficacy of recombinant human growth hormone in Canada.[105] The confluence of these events prompted Canadian authorities and physicians to accelerate

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98. See *Commercial Biotechnology*, *supra*, note 97 at 143-44.

99. Beak Consultants, *supra*, note 94 at 3.12. See also Harold M. Schmeck, "Cell Growth Factors Emerge as Potent Therapies" *New York Times* (28 March 1989) C1.

100. See Ronald W. Ellis, "Vaccines, Diagnostic Proteins and Hormones" in H.-J. Rehm and G. Reed, eds, *Biotechnology*, vol. 7B (New York: VCH Publishers, 1989) 167 at 170-71.

101. See Beak Consultants, *supra*, note 94 at 3.12.

102. See "20-Year MRC Growth Hormone Trial Draws to Successful Conclusion" (1988) 17:2 MRC Newsletter 7.

103. Charles McLean et al., "The Extraction, Purification and Synthesis of Anterior Pituitary Hormones for Therapeutic and Diagnostic Use" in Colin Beardwell and Gary L. Robertson, eds, *The Pituitary* (London: Butterworths, 1981) 238 at 239.

104. See page 133, below.

105. See MRC Newsletter, *supra*, note 102. See also P. Brown, "Human Growth Hormone Therapy and Creutzfeldt-Jakob Disease: A Drama in Three Acts" (1988) 81:1 Pediatrics 85. The availability of recombinant HGH has apparently occasioned new ethical and economic concerns. See John Lantos, Mark Siegler and Leona Cuttler, "Ethical Issues in Growth Hormone Therapy" (1989) 261:7 JAMA 1020.

clinical trials which resulted in the licensing of recombinant human growth hormone in 1986. Today, Canada relies on recombinant human growth hormone for treatment purposes. These developments likely erode the need for presumed-consent legislation for the procurement of cadaver pituitaries.

II. Therapeutic Supply Sources

Although human beings provide most of the tissues and bodily parts needed in tissue transplant treatments, animals, artificial and synthetic products and tissue banks also serve as sources.

A. Animals

Animals currently play three critical roles in tissue transplant treatment. First, society has long relied on them as laboratory models for developing and refining experimental and surgical procedures for later application to human beings. For instance, human liver transplants were predicated on decades of work in animal laboratories.[106] Secondly, some patients depend on animal-derived hormones for medical treatment. The diabetic's use of insulin extracted from animal pancreases is the classic example. Thirdly, the use of catgut as absorbable sutures, pig heart valves in heart valve replacement surgery[107] and pig skin and bovine amnion as biological dressings[108] for burn victims illustrates that animal tissues serve as temporary and permanent grafts.

Whether animals should serve as a direct source for human organ transplants depends on medical research and related ethical and legal issues. These concerns were demonstrated in 1984, when a California surgeon attempted a cross-species transplant involving infant "Baby Fae." The idea of xenografts apparently dates from prehistoric times; they were initially practised in the 1900s using rabbit, pig and sheep kidneys.[109] The development of kidney transplants in the early 1960s helped resurrect the idea in the form of vital organ transplants from primates.[110] The Baby Fae case marked the first transplant of a baboon's heart into an infant who suffered from a rare heart defect that usually claims life within a month after birth.[111] Baby Fae survived twenty days before her body rejected the foreign tissue.[112]

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106. See, *e.g.*, Starzl et al., *supra*, note 75 at 614-15.

107. See Peter Bloomfield et al., "Twelve-Year Comparison of a Bjork-Shiley Mechanical Heart Valve with Porcine Bioprostheses" (1991) 324:9 N. Engl. J. Med. 573.

108. See Arnold Luterman and P. William Curreri, "Skin Transplantation" in Cerilli, *supra*, note 66 at 630. See also A.S. Brown and L.R. Barot, "Biologic Dressings and Skin Substitutes" (1986) 13:1 Clinics in Plastic Surgery 69.

109. Council on Scientific Affairs, American Medical Association, "Xenografts: Review of the Literature and Current Status" (1985) 254:23 JAMA 3353.

110. *Ibid.*

111. L.L. Bailey et al., "Baboon-to-Human Cardiac Xenotransplantation in a Neonate" (1985) 254:23 JAMA 3321.

112. *Ibid.*

The case provoked considerable controversy over several issues, namely:

- whether the institution had complied with federal laws governing such research;[113]
- whether there existed a reasonable hope of benefit for Baby Fae, or whether she simply served as a research instrumentality for science;[114]
- whether her parents were able to give informed consent, in view of evidence that the prospects for survival may have been overstated while the availability of human hearts may have been understated;[115]
- whether xenografts violate natural law or the respect that is due another species, by reducing animals to pure instruments of human welfare;[116] and
- whether societal resources should be allocated to such exotic medical experimentation even "where no reasonable alternative therapy exists."[117]

Approval of such a case in a Canadian university would depend on the deliberations and research protocols of the institutional research ethics board.[118] The Baby Fae case demonstrates that medical research of this nature is fraught with ethical and legal concerns. While those concerns likely justify rigorous review and some prohibitions, a permanent ban may foreclose the possibility of therapeutic xenografts for Canadians.

B. Human Beings

Human beings constitute the main source of transplantable tissue. The specific tissue sources may be categorized into excretions or by-products such as sweat, urine or afterbirth; regenerative substances and tissues such as skin, milk, blood or bone marrow; non-regenerative organs, for example, the heart, kidney or liver; and whole bodies or corpses.[119] Hair and teeth may overlap or not easily fit into defined categories. Still, the

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113. See 45 C.F.R. s. 46.

114. Robert M. Veatch, "The Ethics of Xenografts" (1986) 18:3 (Supp. 2) Transplant. Proc. 93.

115. See U.S. Department of Health and Human Services, National Institute of Health, *Report of the National Institute of Health Site Visit* (Washington, D.C.: U.S. Government Printing Office, 1986) at 5-6. See also George J. Annas, "Baby Fae: The 'Anything Goes' School of Human Experimentation" (1985) 15:1 Hast. Cent. Rep. 15 at 16.

116. Veatch, *supra*, note 114 at 94. See also Strachan Donnelley and Williard Gaylin, "Case Studies: The Heart of the Matter" (1989) 19:1 Hast. Cent. Rep. 26. For discussion of crimes against animals, see LRC, *Recodifying Criminal Law: Revised and Enlarged Edition of Report 30*, Report 31 (Ottawa: The Commission, 1987) at 97.

117. Arthur L. Caplan, "Ethical Issues Raised by Research Involving Xenografts" (1985) 254:23 JAMA 3339 at 3342.

118. See Medical Research Council of Canada, *Guidelines on Research Involving Human Subjects* (Ottawa: Supply and Services Canada, 1987) at 19 [hereinafter MRC]. For human experimentation case law, see *infra*, note 376.

119. See Michèle Harichaux, "Le Corps Objet" in Raphaël Draï and Michèle Harichaux, eds, *Bioéthique et Droit* (Paris: P.U.F., 1988) 130 at 132-36.

categories can prove significant. For example, the donation of regenerative tissue, usually by living donors, generally involves minimal physical invasiveness and medical risk.[120]

By contrast, most non-regenerative tissues and organs come from deceased adult donors — that is, cadavers. Kidney transplants from living donors are the notable exception. Living kidney donors constituted some 15 per cent of the donor pool in Canada in 1989.[121] Infants and children may also be organ donors, although their capacity to consent to live donations and their particular vulnerability raise special legal and ethical concerns.[122]

C. Artificial and Synthetic Sources

Artificial and synthetic replacements of human bodily parts have long been used to treat illness and injury. Artificial limbs were developed centuries ago to replace arms and legs, often severed in combat. False teeth were used as early as 700 B.C.; their modern form emerged in the eighteenth or nineteenth century, to replace teeth transplants from living donors and the occasional trade in teeth from battlefield corpses.[123] Today, artificial tissue replacement technologies range from synthetic blood vessels to mechanical heart valves, to rDNA insulin, the genetically engineered hormone from the human pancreas. Synthetic lenses, artificial eyes and electronic hearing-aids have become common. By contrast, artificial devices to replace the human lung, heart, liver or pancreas are recent, more complicated phenomena.[124] Indeed, few safe and effective artificial organs have been licensed under federal law in Canada. The limited success of the artificial heart exemplifies the rule. The widespread use of the artificial kidney illustrates the exception.

(1) The Artificial Kidney

The artificial kidney, or renal dialysis, is the only artificial organ that has moved beyond experimental to routine therapy for irreversible organ failure. Following decades of research, experimentation and refinement, long-term dialysis was introduced into clinical practice in the 1960s.[125] Today, dialysis provides safe, effective treatment for many of

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120. But see *Cox* v. *Saskatoon*, [1942] 1 W.W.R. 717 (Sask. C.A.) (awarding blood donor damages for transfusion infection).

121. 138 of 902. See CORR, *supra*, note 67. The 15-per-cent figure is consistent with previous years and parallels a 20-per-cent figure in the U.S. See *Canadian Renal Failure Register: 1986 Report* (Ottawa: Kidney Foundation of Canada, 1987) at 119, 122 [hereinafter CRFR]; and U.S. Department of Health and Human Services, *supra*, note 65 at 14. See generally, Peter G. Blake and Carl J. Cardella, "Kidney Donation by Living Unrelated Donors" (1989) 141:8 C.M.A.J. 773.

122. See chaps 2 and 3, below.

123. Jeanne Thomas, "Fangs for the Memories: False Teeth Have Come a Long Way over Century" *The Medical Post* (11 April 1989) 71.

124. See Harold M. Schmeck, *The Semi-Artificial Man* (New York: Walker, 1965).

125. See William Drukker, "Hemodialysis: A Historical Review" in William Drukker, Frank M. Parsons and John F. Maher, eds, *Replacement of Renal Function by Dialysis*, 2d ed. (Boston: Martinus Nijhoff, 1983) 3 at 28.

the conditions that cause irreversible kidney failure. In 1989, some 5,600 patients received dialysis at dozens of centres across Canada.[126]

Dialysis treatment typically requires three weekly visits of between three and four hours each to a dialysis centre. Because chronic dialysis patients must follow a strict regime of treatment and diet, the life-saving technology does impose quality-of-life restrictions. Owing to age and other medical factors,[127] some 40 per cent of the patients in Canada who received dialysis in 1986 were not candidates for kidney transplantation.[128]

Because the artificial kidney is the only non-experimental artificial vital organ, it plays a unique role after transplant failure. The minority of kidney transplant recipients whose transplantation fails has, in theory, two live-saving options: retransplantation and the artificial kidney. Recipients of other vital organs face a statistically greater chance of transplant failure.[129] In the event of failure, they have no safe and effective artificial organ to which they can return while awaiting another transplant.

(2) The Artificial Heart

Therapeutic use of the artificial heart is less advanced. Some heart assistance devices such as implantable pacemakers and synthetic and mechanical heart valves were developed in the 1960s and are now routinely used in treatment.[130] However, the implantable artificial heart remains an experimental medical device[131] which thus affords patients neither the safety nor the quality of life that kidney dialysis does. Artificial heart patients run the risk of blood clots, infections and a diminished quality of life.[132]

At the few Canadian hospitals using the artificial heart, the device has served as a "temporary bridge" to heart transplantation. Such use gained currency following attempts to implant a permanent, artificial heart in five patients in the United States in the early 1980s.[133] Implantation did permit some patients to be mobile and resume normal routines during their 10 to 620 days of extended life.[134] But their quality of life was compromised

126. CORR, *supra*, note 67 at 5,155.

127. OTA, *Life-sustaining Technologies and the Elderly* (Washington, D.C.: OTA, 1987) at 249.

128. CRFR, *supra*, note 121 at 119, 131-32 (1,506 of 3,484 registered dialysis patients, 43%, medically unsuitable candidates for transplant).

129. See table 1, *supra* at 9.

130. See Wilfred Lynch, *Implants: Reconstructing the Human Body* (New York: Van Nostrand Reinhold, 1982) at 53, 75.

131. As an experimental medical device, its use is governed by federal research guidelines and federal medical devices law. See MRC, *supra*, note 118 at 19. See also chap. 3, below.

132. See Steven H. Miles et al., "The Total Artificial Heart: An Ethics Perspective on Current Clinical Research and Deployment" (1988) 94:2 Chest 409.

133. See Gideon Gil, "The Artificial Heart Juggernaut" (1989) 19:2 Hast. Cent. Rep. 24.

134. William C. DeVries, "The Permanent Artificial Heart" (1988) 259:6 JAMA 849.

by massive strokes, chronic infection and chronic hospitalization.[135] The device continues to provoke wide ethical debate.[136]

(3) Genetically Engineered Cells, Tissues and Drugs

Genetically engineered insulin, anti-cancer agents, human growth hormone, and blood-clotting factors have already been described; moreover, biosynthetic skin, veins, glands and valves are at different stages of development and use.[137] Ongoing research on rDNA cell growth factors further suggests how these new tissue replacement technologies may help to ease the demand for scarce therapeutic tissues. Genetically engineered cell growth factors replicate and propagate growth-promoting substances that are produced naturally in the human body. They are expected to be used in treatment ranging from attacking cancer cells to aiding bone marrow transplants.[138]

Clinical trials have recently examined the use of growth factors to stimulate red blood cell production to treat anemia, which is a deficiency in red blood cells. Kidney dialysis and transplant patients often require repeated blood transfusions to treat the anemic side-effects of kidney failure. Scientists have found that the increase in red blood cells from taking the genetically engineered hormone, erythropoietin, tends to reduce the frequency of transfusions, and thus the patient's quality of life is enhanced.[139] Canadian and United States federal drug authorities approved erythropoietin as safe and effective for such treatments in 1989-90.[140]

D. Tissue Banking and Preservation

When removed from the body, tissue is deprived of blood and the essential nutrients and oxygen that blood carries. Normally, such deprivation results in damage or death to

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135. *Ibid.*

136. See Miles et al., *supra*, note 132. Compare George J. Annas, "Death and the Magic Machine: Informed Consent to the Artificial Heart" (1987) 9 W. New Engl. L. Rev. 89; and U.S. Department of Health and Human Services, The Working Group on Mechanical Circulatory Support of The National Heart, Lung, and Blood Institute, *Artificial Heart and Assist Devices: Directions, Needs, Costs, Societal and Ethical Issues* (Washington, D.C.: National Institute of Health, 1985).

137. See Bloomfield et al., *supra*, note 107; text accompanying notes 97 to 105, *supra*; *infra*, note 206; and chap. 3, table 2, *infra* at 121. See also E. Bell and M. Rosenberg, "The Commercial Use of Cultivated Human Cells" (1990) 22:3 Transplant. Proc. 971; Lawrence M. Fisher, "3 Companies Speed Artificial Skin" *New York Times* (12 September 1990) D1; and "Biomatériaux: l'avenir de l'homme-prothèse" *Le Monde* (5 September 1990) 25.

138. See Michael B. Sporn and Anita B. Roberts, *Peptide Growth Factors and Their Receptors* (New York: Springer-Verlag, 1990).

139. See Joseph W. Eschbach et al., "Treatment of the Anemia of Progressive Renal Failure with Recombinant Human Erythropoietin" (1989) 321:3 N. Engl. J. Med. 158.

140. See Rhonda L. Rundle, "Biotech Battlefront: Amgen, Cleared to Sell Kidney Patient Drug, Still Faces Big Hurdles" *Wall Street Journal* (2 June 1989) A1. For discussion of U.S. biotech company patent disputes over EPO see also *Amgen Inc.* v. *Chugai Pharmaceutical Co.*, *infra*, note 776.

the tissue. In tissue preservation, an attempt is made to suspend this degenerative process. Through medical science, tissue can be frozen and chemically preserved for treatment and research purposes.[141]

As with transplant technology, medical scientists began mastering the therapeutic storage of simple tissues before developing preservation methods for kidneys and other complex tissues and vital organs. Tissue banking is largely a post-World-War-II development which began with the routine storage of blood in the 1940s.[142] Developments since then have lead to the routine storage of regenerative bodily substances such as blood, sperm, skin, bone marrow, cells and milk from living donors, and non-regenerative tissues such as heart valves, veins, tendons, nerves, bones and corneal tissue from cadavers.[143] Currently, tissue banks "range in size and complexity from comprehensive centres . . . to small local operations providing one type of tissue for one physician, and under that physician's own responsibility."[144]

Unfortunately, even today tissue banks do not exist for livers, kidneys and hearts. Under current transplantation practice, those vital organs require virtually continuous perfusion with blood to prevent deterioration. Using traditional preservation solutions, surgeons generally have only hours — at the most, days — between removal of the organ from the donor and its implantation into the recipient.[145] A recently approved new chemical preservative, the UW solution, may double or triple the time surgeons have to get a donated organ to a transplant recipient.[146] Still, the contrast with the more generous time constraints of tissue procurement, the narrow period in which transplant surgeons must work and the non-regenerativeness of vital organs combine to accentuate the necessity of rapidly and properly matching and transplanting organs that become available.

Milk Banks: Human milk was one of the first bodily substances to be banked for therapeutic use. The first Canadian milk bank was established during the 1920s at the Winnipeg Children's Hospital.[147] By the mid-1980s, some twenty banks were in existence.[148] They provide human milk to infants who are unable to obtain a sufficient supply from their own mothers.[149] While women in some countries are paid to donate

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141. See R. Razaboni and W.W. Shaw, "Preservation of Tissue for Transplantation and Replantation" (1983) 10:1 Clinics in Plastic Surgery 211 at 212-13.

142. See text accompanying notes 33-35, *supra*.

143. See *Report of the Alberta Human Tissue Procurement Task Force* (Edmonton, Alta: The Task Force, 1985) at 24.

144. *Ibid.* For legal responses to such developments, compare *An Act to amend the Public Health Protection Act*, S.Q. 1990, c. 55 and a recent Belgian Crown Order, *infra*, note 958.

145. See table 1, *supra* at 9.

146. See *ibid.* See also Satoru Todo et al., "Extended Preservation of Human Liver Grafts with UW Solution" (1989) 261:5 JAMA 711; Folkert O. Belzer and James H. Southard, "Principles of Solid Organ Preservation by Cold Storage" (1988) 45:4 Transplant. 673 at 675.

147. Gilbert Sharpe, *The Law & Medicine in Canada*, 2d ed. (Toronto: Butterworths, 1987) at 330.

148. See Canadian Pediatric Society, Nutrition Committee, "Statement on Human Milk Banking" (1985) 132:7 C.M.A.J. 750.

149. R.S. Sauvé et al., "Mothers' Milk Bank: Microbiologic Aspects" (1984) 75 Can. J. Public Health 133.

milk at supermarkets that serve as distribution centres, the Canadian practice has been to encourage mothers to donate gratuitously to hospital-based milk banks.[150] Donated human milk may be refrigerated twenty-four to forty-eight hours or frozen for up to six months.[151]

Blood Banks: Blood-banking technology has become more sophisticated and its use routine since its origins in the 1940s.[152] The length of storage before therapeutic use depends on the blood product. Whole blood may be refrigerated some thirty-five days, frozen plasma may be stored for three to twelve months, and frozen red blood cells may be stored for up to ten years.[153] With 900 blood banks estimated to exist in Canada, blood banking is the most common and most frequently used tissue-banking practice.[154]

Eye Banks: The first Canadian eye bank was established at the University of Toronto in 1955.[155] Today, ten eye banks provide services across Canada. Donated corneas are obtained from deceased donors and stored in a refrigerated tissue solution for up to three or four days.[156] Some banks freeze and store viable corneas, which they later thaw for transplantation. The three- to four-day refrigeration method used by most Canadian eye banks, however, means that they function as centres for the collection, grading and distribution of fresh corneas.[157] From April 1988 to March 1989 Canadian eye banks procured, stored or distributed over 5,000 donor eyes. Some 600 eyes were either placed in long-term storage or processed and stored for use as live contact lenses, 1,800 were used for research and teaching and 2,300 were transplanted.[158]

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150. Compare the results of a 1981 survey identifying one Canadian bank as paying donors, with the Finnish practice of paying donors $20/litre. See Calgary Mothers' Milk Bank, *Mothers' Milk Bank Manual* (Calgary, Alta: Calgary Mothers' Milk Bank, 1984) at 5 and Martti A. Siimes and Niilo Hallman, "A Perspective on Human Milk Banking 1978" (1979) 94:1 J. Pediatr. 173. Personal communication with Professor Siimes revealed that the 1977 figure of $13/litre has been increased to $20/litre.

151. HWC, *Infection Control Guidelines for Perinatal Care* (Ottawa: HWC, 1988) at 11-12; HWC, *Family-Centred Maternity and Newborn Care: National Guidelines* (Ottawa: Supply and Services Canada, 1987) para. 7.11 at 72. While milk banks are generally regulated by professional guidelines in Canada, other jurisdictions have enacted legislation and regulations to govern their practices and procedures. See, *e.g.*, N.Y. Pub. Health Law, ss 2505, 4360 (McKinney, 1991 Supp.), and French milk banks regulations, *infra*, note 934.

152. See section I.B(1), above.

153. See CBC, *supra*, note 35 at 34, citing CRSC, *Clinical Guide to Transfusion: Products and Practices*, 2d ed. (Ottawa: The Society, 1987) at 29.

154. One bank per 17 CRCS transfusion centres, plus one bank per 882 hospitals that received CRCS-distributed blood products in 1988-89. See *Blood Services Statistical Report 1988-89*, *supra*, note 37 at 58.

155. See Anne Wolf, "The Eye Bank of Canada, 1951 to 1988" [unpublished] at 1.

156. See Council on Scientific Affairs, *supra*, note 56 at 720.

157. See Manitoba Law Reform Commission, *Report on the Human Tissue Act*, Report 66 (Winnipeg: The Commission, 1986) at 5 [hereinafter MLRC]; Cox, *supra*, note 62 at 10.

158. Of 2,342 transplanted corneas, 301 involved fresh corneas usually used within 24 hours, 1,994 had been refrigerated for transplant within one to four days and 47 transplants involved corneas frozen before March 1988. Eye Bank of British Columbia, "Canadian Eye Bank Statistics, April 1st 1988 to March 31st 1989" [unpublished].

Sperm Banks: Donated human sperm may be frozen and banked for years before being thawed for use in infertility treatment. The first successful pregnancies resulting from frozen sperm were reported in the 1950s.[159] Artificial insemination in Canada began in the late 1960s.[160] A survey of eighteen Canadian artificial insemination centres, conducted in the early 1980s, elicited eleven responses: three reported regularly using frozen semen while eight relied on fresh semen.[161] Today, artificial insemination is "widely practiced using both fresh and frozen semen."[162] While the use of frozen semen has been more prevalent in some foreign jurisdictions,[163] recent concerns about the risks of HIV infection have led to calls in Canada for the mandatory and exclusive use of frozen semen to enable a more accurate screening of donors.[164] The increased practice of freezing other reproductive tissues is also becoming a component of modern infertility treatment.[165]

Cell and DNA Banks: Extended refrigeration and the long-term freezing of viable human cells have facilitated the development of cell and DNA banking, as an aid in the diagnosis of diseases. Frozen human cells may remain viable for as long as twenty years.[166] Such long-term storage of cells facilitates research and enables diagnostic comparisons to be made, for example, between cells suspected of having genetic abnormality and stored cells known to have genetic abnormality. This work is carried out by such entities as the Repository for Mutant Human Cell Strains at the Montreal Children's Hospital.

DNA banking also plays a role in the diagnosis of genetic disease. A DNA bank "is a facility that stores DNA for future analysis."[167] DNA may be extracted from the cells of preserved blood, fresh or frozen tissues or viable cells, and may then be stored indefinitely in micro-vials for later use in diagnosis. In a national screening program for Huntington's disease, recently undertaken at fourteen Canadian centres, to test whether patients carry the Huntington's disease gene, a DNA sample extracted from preserved tissue of a deceased

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159. See R.G. Bunge, W.C. Keettel and J.K. Sherman, "Clinical Use of Frozen Semen: Report of Four Cases" (1954) 5 Fertil. Steril. 520.

160. See Jacques E. Rioux and C.D.F. Ackman, "Artificial Insemination and Sperm Banks: The Canadian Experience" in Georges David and Wendel S. Price, eds, *Human Artificial Insemination and Semen Preservation* (New York: Plenum Press, 1980) 31.

161. HWC, *Report of the Advisory Committee on the Storage and Utilization of Human Sperm* (Ottawa: HWC, 1981) at x, 72.

162. HWC, Federal Centre for AIDS, *Guidelines for Prevention of HIV Infection in Organ and Tissue Transplantation* (October 1989) 15S4 (Supp.) Canada Diseases Wkly Rpt at 17 [hereinafter FCA].

163. See Derek J. Jones, "Artificial Procreation, Societal Reconceptions: Legal Insight from France" (1988) 36 Am. J. Comp. L. 525.

164. See FCA, *supra*, note 162 at 4 (use of fresh semen not recommended). See also The Canadian Fertility and Andrology Society, *Guidelines for Therapeutic Donor Insemination* (Montreal: The Society, 1988) at 3.

165. See LRC, *Medically Assisted Procreation*, Working Paper 65 (Ottawa: The Commission, 1992) and American Medical Association, "Board of Trustees Report: Frozen Pre-Embryos" (1990) 263:18 JAMA 2484. For a discussion of litigation over frozen embryos, see *infra*, note 415.

166. Linda Madisen et al., "DNA Banking: The Effects of Storage of Blood and Isolated DNA on the Integrity of DNA" (1987) 27 Am. J. Med. Genet. 379 at 388.

167. Ad Hoc Committee on DNA Technology, American Society of Human Genetics, "DNA Banking and DNA Analysis: Points to Consider" (1988) 42:5 Am. J. Human Genet. 781 [hereinafter ASHG].

relative of the patient may be required if preserved blood has not been stored.[168] In those screening trials, the need for preserved tissue has sometimes been met by the Canadian Brain Tissue Bank in Toronto. For years that Bank has been storing donated brain tissue for research purposes.[169] More recently, it has provided, to genetic analysts, brain tissue of deceased relatives from which the analysts then extract DNA and test it for Huntington's disease. If the genes for other degenerative brain conditions such as Alzheimer's disease are identified, the Bank might play a similar and perhaps expanded role.[170]

Bone Banks: Canada has some sixty bone banks,[171] which are capable of storing frozen bone indefinitely.[172] Bone is used largely in reconstructive surgery, such as in the treatment of tumours or fractures,[173] after it is procured from living and cadaver donors. Living donors may donate bone for removal during such surgery as total hip or total knee replacement.[174] Cadaver bones, typically the long bones of the leg and arms, may be procured independent of, or in conjunction with, organ procurement.[175]

As these tissue-banking technologies have evolved, so too have their medical and societal functions.[176] The ability to preserve a spectrum of human tissue and bodily substances has generated a common cluster of issues for tissue banks: What are the medical and non-medical criteria for donor and recipient participation?[177] What are the requirements and consequences of donor and recipient informed consent?[178] What are the

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168. See Madisen et al., *supra*, note 166 at 380. See also Lawrence Surtees, "Doctors Using New Gene Probes in Huntington's Disease Program" *The [Toronto] Globe and Mail* (29 August 1988) A14; Kathleen Nolan and Sara Swenson, "New Tools, New Dilemmas: Genetic Frontiers" (1988) 18:5 Hast. Cent. Rep. 40. See generally, Note, "Legal Implications of the G-8 Huntington's Disease Genetic Marker" (1988-89) 39 Case W. Res. L. Rev. 273.

169. For British practices, see Diana Brahams, "Brain Banks" (1990) 335:8684 Lancet 282.

170. See Harold M. Schmeck, "Gene-Mappers Identify Dozens of Trouble Spots" *New York Times* (20 June 1989) C1 at C6 (gene-mappers seek to identify chromosomes or genes related to Alzheimer's disease, Down's syndrome, dwarfism, epilepsy).

171. Compare Gordon Russell, Richard Hu and Jim Raso, "Bone Banking in Canada: A Review" (1989) 32:4 Can. J. Surg. 231 and FCA, *supra*, note 162 at 17.

172. Nikki Jackson Jacobs, "Establishing a Surgical Bone Bank" in Kenneth Fawcett and Alice R. Barr, eds, *Tissue Banking* (Arlington, VI: American Association of Blood Banks, 1987) 67.

173. See *ibid.* See also Allan E. Gross, "The Use of Allografts in Orthopedic Surgery" (1989) 6 Transplantation/Implantation Today 44.

174. Jacobs, *supra*, note 172.

175. See William W. Tomford and Henri J. Mankin, "Cadaver Bone Procurement" in Fawcett and Barr, *supra*, note 172, 97.

176. See generally T.F. Kirn, "Tissue Banking in Midst of Revolution of Expansion as More Uses Are Found for Various Transplants" (1987) 258:3 JAMA 302.

177. See Ken Pole, "Red Cross Challenged over Blood Donor Policy" *The Medical Post* (20 June 1989) 12 (CRCS-directed blood donor policy challenged). For discussion of litigation over rights to participate in sperm bank services, see Jones, *supra*, note 163.

178. Does consent establish rights over the control and transfer of tissue? See Bartha M. Knoppers and Claude M. Laberge, "DNA Sampling and Informed Consent" (1989) 140:9 C.M.A.J. 1023 at 1027. See also *infra*, note 184.

contours of any duty to maintain confidential medical records?[179] Should banking procedures be regulated by professional standards or legislation?[180] To what extent should a bank be liable for furnishing diseased tissue?[181]

Thus, if new tissue-banking practices tend to create new functions, they may also create new issues. Autologous, "self-directed" tissue banking is an example. In contrast to traditional donors, who may give anatomical gifts to society at large through a tissue bank, autologous or self-directed donors of blood, bone marrow, DNA and reproductive matter might more accurately be called "depositors," for they bank their tissue for later use in treating their own or a family member's medical conditions.[182]

The recent Canadian practice of banking one's blood at a Red Cross centre or at a commercial, autologous blood bank exemplifies the trend.[183] Such deposit practices tend to modify the relationship between the tissue bank and the tissue depositor, particularly regarding control or ownership of the deposited material.[184] Finally, it should be noted that, beyond serving as repositories to assist medical treatment and research, tissue banks also assist commercial undertakings, for example, by storing patented human cell lines and human biologics.[185]

III. Co-ordinating Supply and Demand

To co-ordinate supply and demand, tissue exchange networks have developed from the local to the international level. Some efforts are structured within a cohesive national system. For example, the seventeen Canadian Red Cross transfusion centres largely serve regional blood collection and distribution needs within the framework of the national blood services, common principles and uniform procedures.[186] The system results from forty years of experience and evolution.

Tissue donor registries and organ exchange networks are more recent. Donor registries centralize the names and medical data of potential organ donors to facilitate the rapid matching of tissue types between a transplant patient and a potential donor. To expand

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179. See generally Lorne Elkin Rozovsky and Fay Adrienne Rozovsky, eds, *The Canadian Law of Patient Records* (Toronto: Butterworths, 1984). See also chap. 3, below.

180. See *supra*, note 151.

181. See *infra*, notes 501-503.

182. See ASHG, *supra*, note 167 at 782.

183. See Anne Gilmore, "Red Cross Gets Go-Ahead for Autologous Blood Service" (1988) 138:2 C.M.A.J. 157. See also *Blood Services Statistical Report 1988-89*, *supra*, note 37 at 11 (autologous collection at 17 CRCS centres); National Blood Resource Education Program Expert Panel, "The Use of Autologous Blood" (1990) 263:3 JAMA 414.

184. See ASHG, *supra*, note 167 at 782 ("Banked DNA is the property of the depositor unless otherwise stipulated"). See also chap. 3, below.

185. See American Type Culture Collection, *Catalogue of Cell Lines and Hybridomas*, 5th ed. (Rockville, Md: American Type Culture Collection, 1985) at vi.

186. See text accompanying notes 34-39, above.

the existing bone marrow transplant pool between unrelated donors and recipients, for example, the Canadian Red Cross Society recently established a national registry of 100,000 bone marrow transplant donors, who would provide compatible tissue to Canadian bone marrow transplant centres.[187] The Canadian Red Cross estimates that the registry will benefit an additional 400 bone marrow transplant patients annually.[188]

Organ exchange networks build on these information-exchanging principles. Nine provincial organ retrieval programs operate in Canada.[189] The first such network was established as a collaborative effort between four transplant centres in Toronto in 1976. By 1978, the Metro Organ Retrieval and Exchange (MORE) program functioned province-wide. It maintains a twenty-four-hour organ retrieval team, offers advice to referring hospitals and arranges for the transfer of donors to transplant centres.[190] Similar organ retrieval programs are now in operation in British Columbia, Manitoba, Saskatchewan, Alberta, the Maritimes and Quebec.[191]

Retrieval programs and transplant centres play critical roles in the organ donation process. The process begins by identifying potential donors. The typical donor has suffered irreversible brain injury, often from a car accident. Not surprisingly, then, most potential donors originate from the intensive care units of major hospitals.[192] Once a potential donor is identified, it is determined whether he or she has indicated a willingness to donate (for example, by driver's licence). If not, the potential donor's next of kin, who is authorized by law to consent or decline,[193] may be approached to discuss the possibility.

Following the certified brain death of the donor, which may require some twenty-four hours,[194] the next of kin signs the necessary consent forms. The donor is thereafter mechanically maintained and given continuous intensive clinical and biochemical monitoring, to preserve the organs for transplantation.[195] Monitoring may include administering antibiotics to fight infection, checking blood pressure and body temperature,

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187. See *supra*, notes 50 and 51. Compare the U.S. registry involving 50 blood banks and 17 bone marrow transplant centres. Jane E. Brody, "New Registry Is Raising Hope for Those in Need of Bone Marrow" *New York Times* (12 January 1988) C1.

188. *Ibid.*

189. Anne Gilmore, "Procuring Donor Organs: Firm but Friendly Encouragement Required" (1986) 134:8 C.M.A.J. 932 at 937.

190. ONT, *supra*, note 29 at 114.

191. See Federal-Provincial Advisory Committee on Institutional and Medical Services, Subcommittee on Institutional Programs, *Organ and Tissue Donation Services in Hospitals: Guidelines for Establishing Standards for Special Services in Hospitals* (Ottawa: Supply and Services Canada, 1987) at 42-45.

192. ONT, *supra*, note 29 at 103. Joseph M. Darby et al., "Approach to Management of the Heartbeating 'Brain Dead' Organ Donor" (1989) 261:15 JAMA 2222 (98%).

193. See chap. 3, below.

194. See Canadian Congress on Neurological Sciences, "A CMA Position: Guidelines for the Diagnosis of Brain Death" (1987) 136:2 C.M.A.J. 200A. See also Canadian Congress Committee on Brain Death, "Death and Brain Death: A New Formulation for Canadian Medicine" (1988) 138:5 C.M.A.J. 405.

195. See ONT, *supra*, note 29 at 93.

rotating the body to prevent skin ulcers, registering hourly urine output and even resuscitating the minority of brain-dead, mechanically maintained donors who undergo heart failure during the maintenance phase.[196] The matching of blood and tissue types also precedes the actual surgical procedure. Donor tissue and blood must be rigorously screened to detect transmissible diseases.[197]

When a possible match is confirmed, one of three procurement options will be pursued. For some of the more established procurement and transplant procedures, such as kidney transplants, a medical team at the donor hospital may simply excise the kidney and ship it. Alternatively, the donor may be transported to the recipient hospital,[198] or a procurement team may drive or fly to the donor hospital. In the latter case, the organ is surgically removed, packed in ice and quickly returned by the procurement team to the recipient hospital. Surgical implantation of the organ may then begin. Some thirty-two hours are needed to co-ordinate the retrieval and transplantation of an organ such as a kidney: multiple organ retrieval from a single donor requires another ten hours.[199] Co-ordinating the supply of and demand for tissue sometimes necessitates international transfers.[200]

IV. Emerging Supply-and-Demand Dilemmas

The apparent shortfalls between the supply of and demand for tissue accentuate dilemmas confronting societies with advanced tissue transplant technologies. The dilemmas are illustrated by debates over tissue sales, consent requirements, bodily property and allocating scarce organs.

A. Scarcity, Payments and Biocommerce

To what extent should society prohibit or regulate the sale of human bodily parts and tissues? Some Canadian analysts have suggested regulated sales as a solution to organ shortages.[201] If sales are to be prohibited or regulated, how should they be defined? Are all payments that accompany tissue transfers "sales" money? What of tissues imported for Canadian patients from foreign jurisdictions where donors of semen, blood products, milk, bone marrow, placentas and kidneys receive payment in association with anatomical donations?

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196. See Darby et al., *supra*, note 192 at 2225-26.

197. See FCA, *supra*, note 162 (despite HIV transmission in other countries, no documented cases of HIV transmission in Canadian kidney, liver, heart, heart/lung, cornea, skin, bone, bone marrow, transplants; one reported case of HIV transmission associated with surrogate motherhood) at 1-2; U.S. Centers for Disease Control, "Semen Banking, Organ and Tissue Transplantation, and HIV Antibody Testing" (1988) 259:9 JAMA 1301. For case law regarding negligent screening of transplant tissues, see *infra*, note 501.

198. See A. Grenvik et al., "Multiple Organ Procurement by Interhospital Transfer of Heartbeating Cadavers" (1984) 16:1 Transplant. Proc. 251.

199. Gilmore, *supra*, note 189 at 936.

200. See the discussion of international transfers in chap. 4, below.

201. See, *e.g.*, G. Sharpe, "Commerce in Tissue and Organs" (1985) 17:6 (Supp. 4) Transplant. Proc. 33 at 38.

Canadian reliance on products that derive from commercially processed, imported fractionated plasma illustrates some of the practical realities that structure current public policy on sales. The collection of the plasma component of donated blood is instrumental in modern medical treatment. Fractionated plasma helps derive Factor VIII, a clotting agent used to treat some 2,800 hemophiliacs in Canada.[202] Unfortunately, world-wide need for Factor VIII has greatly exceeded its availability.[203] In Canada, most plasma that is collected by the Canadian Red Cross Society is fractionated into Factor VIII and fifteen other fractionated products by a laboratory in the United States; additional Factor VII plasma by-products are purchased on the international market,[204] which is largely supplied by a commercial plasmapheresis industry in the United States. The American industry, which supplies much of the world market, so relies on paid plasma donations that "[m]ore than half the world's supply of fractionable plasma is obtained by plasmapheresis of paid donors."[205] The development of recombinant Factor VIII may alter national and international plasma markets.[206]

The current Canadian and world shortage of fractionated plasma, however, suggests that the sale and purchase of scarce human biological products may sometimes prove necessary. Dramatic shortfalls between supply and demand tend to create an economic value for scarce biological substances. That such value may translate into open or black market prices magnifies the fundamental question of whether society wishes to adopt an ethic of gift or commercial exchange for some or all tissues and substances. If the ethical aversion to biocommerce remains, how should the law express the aversion in the face of heightened economic value of scarce human tissues and increasingly routine monetary exchanges in their transfer? These considerations will be examined more closely in subsequent chapters.

B. Bodily Integrity and Consent

Modern medical needs and tissue procurement practices also raise several issues concerning consent, the possession and ownership of human tissues and the ethics and legalities of maintaining brain-dead individuals for tissue donation and other medical purposes. The resolution of many of these issues implicates the bodily and moral integrity of living and deceased donors as well as the emotional and religious interests of their families.

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202. Communication with the Canadian Hemophilia Society.

203. Anthony F.H. Britten, "Worldwide Supply of Blood and Blood Products" (1987) 11:1 World J. Surg. 82.

204. CBC, *supra*, note 35 at 72.

205. Britten, *supra*, note 203 at 84.

206. See Simon Jones, "Genetically Engineered Synthetic Factor B Gives Hemophiliacs New Hope" *The Medical Post* (15 November 1988) 11; and Richard Schwartz et al., "Human Recombinant DNA-Derived Antihemophilic Factor (Factor VIII) in the Treatment of Hemophilia A" (1990) 323:26 N. Engl. J. Med. 1801.

(1) Express or Presumed Consent

The informed-consent principle generally holds that health providers may invade a patient's person after securing the patient's consent.[207] The principle applies to transplant recipients and living donors. However, some question the extent to which informed consent should apply to the undeclared, potential donor: namely the deceased hospital patient who has indicated no preference to donate or not while alive.

Should society require the next of kin's consent in such instances? Critics argue that consent poses undue procedural burdens on the organ procurement process, thereby reducing the number of available organs.[208] Instead, it is suggested that society presume consent to the use of the body for medical science, unless there is evidence to the contrary. Whether societal needs for vital organs justify the adoption of presumed consent is a question that merits scrutiny, because it would amend the traditional Canadian approach and because the practice has been adopted in several foreign jurisdictions.

Presumed-consent considerations extend beyond strict tissue scarcity, however. Some have suggested that society should also presume next of kin consent to the hospital use of brain-dead, artificially maintained "cadaver-patients" for medical research, experimentation and the hands-on training of medical school students.[209] Are such proposals ethically and legally defensible? The competing principles of presumed consent and express consent, as well as the interest and values at stake compel a fuller exploration of the issue.

Subsequent chapters will also explore some new and old consent questions. The issues surrounding consent to organ transplantation in minors or incompetents are not novel.[210] The current controversy surrounding consent to anencephalic newborn tissue donation, however, raises newer ethical and legal questions on the definition of death. These, too, will be explored in subsequent chapters.

(2) Bodily Property and Possessory Interests

What does the age-old legal principle that there is "no property in a corpse" mean in the context of increasing therapeutic and biotechnological use, exchange and storage of bodily substances from living and deceased donors?[211] Novel legal conflicts involving the control and ownership of bodily substances have recently arisen in foreign jurisdictions.[212] Some have involved substances deposited in tissue banks. Others have arisen between the sources of human cells and tissues and those persons who procure and use them for biotechnological, therapeutic purposes.[213] Do the human "contributing" sources

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207. See chap. 3, below.

208. See, *e.g.*, Thomas E. Starzl, "Implied Consent for Cadaveric Organ Donation" (1984) 251:12 JAMA 1592.

209. See chap. 3, below.

210. *Ibid.*

211. *Ibid.*

212. *Ibid.*

213. *Ibid.*

have legal interests or rights in the profitable therapeutic fruits of biotechnology? If these developments invite society to rethink its valuing of and legal regard for human tissue, certain conflicts biotechnology has occasioned also challenge us to examine the benefits and limits of attaching property notions to the human body. Some of these questions will be explored.

C. Allocating Scarce Medical Resources

Finally, we feel compelled to draw attention to critical questions that lie beyond the scope of the immediate inquiry. The increasing tension between the conquest of disease and the costs of high technology medicine poses daunting choices in the rationing or societal triage of scarce medical resources.[214] Does Canada's commitment to providing "reasonable access" to medically necessary hospital services[215] entitle patients to organ replacement technology? The scope of any such entitlement is not clear. In British litigation to compel the Ministry of Health to fulfil its "duty to provide comprehensive health services" Lord Denning declared the following:

> As Lord Justice Oliver said in the course of argument, it cannot be supposed that the Secretary of State has to provide all the kidney machines which are asked for, or for all the new developments, such as heart transplants, in every case where people would benefit from them.[216]

Indeed, the extensive monetary and medical resources required for high technology organ transplants have persuaded some analysts[217] to favour allocating resources to health care areas judged to be more needy. Some jurisdictions agree. The state of Oregon, for example, has acted on its obligation to provide reasonable and "medically necessary care"[218] in an era of scarce resources by funding only kidney and corneal transplants in

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214. See P. Morgan and L. Cohen, "The Ottawa Heart Institute: It's Good, but Can We Afford It?" (1990) 142:6 C.M.A.J. 616; Calvin R. Stiller, "High-Tech Medicine and the Control of Health Care Costs" (1989) 140:8 C.M.A.J. 905. See generally, U.S. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research [hereinafter President's Commission], *Securing Access to Health Care* (Washington, D.C.: The Commission, 1983).

215. See discussion of the *Canada Health Act*, chap. 3, section III.A(4), below.

216. *R.* v. *Secretary of State for Social Services* (18 March 1980), (C.A.) [unreported, available on Lexis] discussed in Diana Brahams, "Enforcing a Duty to Care for Patients in the NHS" (1984) 2:8413 Lancet 1224.

217. Compare "Report of the Massachusetts Task Force on Organ Transplantation" (1985) 13:1 Law Med. Health Care 8 and Thomas D. Overcast and Roger W. Evans, "Technology Assessment, Public Policy and Transplantation: Restrained Appraisal of the Massachusetts Task Force Approach" (1985) 13:3 Law Med. Health Care 106. See also H.T. Engelhardt, "Shattuck Lecture — Allocating Scarce Medical Resources and the Availability of Organ Transplantation" (1984) 311:1 N. Engl. J. Med. 66.

218. As in Canada, the obligation derives from participation in the federal medicare program. In the U.S., transplant funding litigation has arisen over whether recent federal transplant laws modify the medicare obligation to provide reasonable and necessary medical care. *Ellis* v. *Patterson*, *infra*, note 1001 at 54 (discussing U.S. transplant funding litigation).

favour of increased funding for maternal and infant health care.[219] If these public choices are best guided by open ethical deliberation, economic analysis and rigorous medical technology assessments, societal and institutional mechanisms for such analyses must be advanced. For while the Federal-Provincial Transplant Working Group concluded that kidney transplants, and to a lesser extent heart and bone marrow transplants, are cost-effective, it also suggested that technology assessment and cost-effectiveness evidence on the newer transplants remain in the early stages of evaluation.[220] The continuing emergence of such evidence will help answer an increasingly basic question: What is the optimal societal investment in primary care and high technology medicine?

Such macro-allocative decisions have clear implications for the health care consumer. Yet, if a decision is made to support or fund organ transplants, on what bases should society allocate scarce organs? Authorities have recently disputed the ethics of excluding patients afflicted with alcohol-based liver diseases from liver transplant waiting lists, for example.[221] The conflict raises the more general question, How should we designate priorities on transplant waiting lists: by medical need; a first-come first-served basis; a lottery; social standing; medical prognosis; or the ability to pay?[222] The answers clearly depend on a host of macro- and micro-allocation considerations.[223] Basic principles of fairness and efficiency, coupled with the deep public interest in tissue donation, may suggest

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219. See Jennifer Dixon and H. Gilbert Welch, "Priority Setting: Lessons from Oregon" (1991) 337:8746 Lancet 891.

220. See FEDS, *supra*, note 29 at 53. See also Evans et al., *supra*, note 66; *Liver Assessment*, *supra*, note 80; R.W. Evans, "The Economics of Heart Transplantation" (1987) 75:1 Circulation 63. For an early technology assessment of bone marrow transplants, see *Cost Effectiveness*, *supra*, note 46. See generally Institute of Medicine, *Assessing Medical Technologies* (Washington, D.C.: National Academy Press, 1985).

221. Compare Carl Cohen et al., "Alcoholics and Liver Transplantation" (1991) 265:10 JAMA 1299; Alvin H. Moss, "Should Alcoholics Compete Equally for Liver Transplantation?" (1991) 265:10 JAMA 1295; Kevin Schwartzman, "*In Vino Veritas?*: Alcoholics and Liver Transplantation" (1989) 141:12 C.M.A.J. 1262; *Allen* v. *Mansour*, 681 F. Supp. 1232 (E.D. Mich. 1986) (state liver transplant selection criteria requiring documented two years abstinence from alcohol is "arbitrary and unreasonable" exclusion); "Alcoholics to Get Low Priority for Liver Transplants, Hospital Rules" *The [Toronto] Globe and Mail* (16 March 1990) A10 (ethically acceptable to give alcoholics low priority for liver transplants).

222. See "Proceedings of a Conference on Patient Selection Criteria in Transplantation" (1989) 21:3 Transplant. Proc. See also John F. Kilner, "Age as a Basis for Allocating Lifesaving Medical Resources: An Ethical Analysis" (1988) 13:3 J. Health Pol. Pol'y L. 405; Arthur L. Caplan, "Equity in the Selection of Recipients for Cardiac Transplants" (1987) 75:1 Circulation 10; Karen J. Merrikin and Thomas D. Overcast, "Patient Selection for Heart Transplantation: When Is a Discriminating Choice Discrimination" (1985) 10:1 J. Health Pol. Pol'y L. 7; Maxwell J. Mehlman, "Rationing Expensive Lifesaving Medical Treatments" [1985] Wis. L. Rev. 239; James F. Blumstein, "Rationing Medical Resources: A Constitutional, Legal, and Policy Analysis" (1981) 59 Tex. L. Rev. 1345; Thomas Halper, *The Misfortunes of Others: End-Stage Renal Disease in the United Kingdom* (New York: Cambridge University Press, 1989); Henri J. Aaron and William B. Schwartz, *The Painful Prescription: Rationing Hospital Care* (Washington, D.C.: Brookings Institution, 1984); Jean de Kervasdoue, John Kimberly and Victor Rodwin, *The End of an Illusion: The Future of Health Policy in Western Industrialized Nations* (Berkeley: University of California Press, 1984); Guido Calabresi and Philip Bobbitt, *Tragic Choices* (New York: Norton, 1978); Note, "Due Process in the Allocation of Scarce Life-Saving Medical Resources" (1975) 84 Yale L.J. 1734; Note, "Scarce Medical Resources" (1969) 69 Colum. L. Rev. 620.

223. See J.B. Dossetor, "Ethical Issues in Organ Allocation" (1988) 20:1 Transplant. Proc. 1053. See generally Deborah Mathieu, ed., *Organ Substitution Technology: Ethical, Legal, and Public Policy Issues* (Boulder, Colo.: Westview, 1988).

that medical practitioners who receive donated human tissues hold these precious resources in public trust and have a societal duty to allocate them equitably and efficiently.[224] Indeed, because the issues implicate fundamental values and pressing questions of distributive justice, they merit the immediate attention of government, professional groups, and the public.

V. Determinants of Supply and Demand

The foregoing overview suggests that the supply and the demand for human tissues and scarce biological substances are evolving and dynamic. The state of transplant technology, the sophistication of tissue procurement networks, legal rights and duties and the moral propriety of particular medical procedures — all may influence supply and demand disequilibria.

Improvements in the state of the art of tissue replacement technology appear to be the initial driving force in the dynamic. Such advances are illustrated by the impact of cyclosporine on organ transplant outcomes and by the development of genetically engineered human growth hormone to replace cadaver pituitary human growth hormone.

Tissue supply and demand depend on non-medical factors as well. Debates over the Baby Fae case, the artificial heart and consent requirements demonstrate that tissue transplants take place in an evolving ethical and legal infrastructure. Moreover, administrative factors may influence tissue supply and demand, as is evidenced by the seventeen Canadian Red Cross blood donor centres, the nine regional organ procurement networks and developing international tissue exchange networks.

Finally, public and professional attitudes exert a telling influence on supply and demand, especially with regard to organ transplantation. Few people take comfort in the practical aspects of confronting death. The chronic discrepancy between the low number of completed tissue donation cards and public poll surveys indicating high support of tissue donation suggests ambivalence about the actual organ donation process.[225]

The ambivalence stems from several factors, including the individual's not having considered the practicalities of organ donation, death anxiety, fear and distrust on the

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224. See USTF, *supra*, note 29 at 80 (donated organs a national resource).

225. See Jan A. Walker et al., "Parental Attitudes toward Pediatric Organ Donation: A Survey" (1990) 142:12 C.M.A.J. 1383 at 1384 (80% surveyed families willing to donate); P.K. Basu, K.M. Hazariwala and M.L. Chipman, "Public Attitudes toward Donation of Body Parts, Particularly the Eye" (1989) 24:5 Can. J. Ophthalmol. 216 (roughly half of the respondents willing to donate had signed donor cards); M. Robinette, "Organ Donation: Factors Contributing to the Imbalance between Demand and Supply" in David R. Grant and William J. Wall, eds, *First Canadian Symposium on Multi-Organ Transplantation: April 28 and 29, 1988* (London, Ont.: University of Western Ontario, Scitex, 1989) 69; Barbara E. Nolan and Nicholas P. Spanos, "Psychosocial Variables Associated with Willingness to Donate Organs" (1989) 141:1 C.M.A.J. 27.

determination of death.[226] The public ambivalence typically results in a recurrent "undeclared donor scenario" in Canadian hospitals — that is, a scenario in which a recently deceased hospital patient, who meets the medical criteria for organ donation, has not made known his or her intentions on donation. The tragedy that has befallen the family of the potential donor understandably tends to make family members unlikely to consider or initiate the donation of their own accord. Should anything be done to further donation in such circumstances? Should a trained medical-bereavement team delicately and supportively take the initiative, since studies suggest that most families actually support being approached as part of their bereavement process?[227] Or, should we spare family members talk on these matters by routinely procuring organs on the presumption that such procurement is justified to save lives and grief and that the deceased would likely support the humanitarian gesture?

Even medical professionals are not immune from ambivalence in resolving the undeclared-donor scenario. Over the last five years, Canadian analysts have repeatedly characterized national organ scarcity as the consequence of medical community reluctance to approach the grieving family of a recently deceased, undeclared, potential donor. In 1985, a federal-provincial transplant task force described professional reluctance as "one of the most significant barriers" to increasing organ donation.[228] That same year, provincial task forces in Ontario and Alberta concluded that such reluctance erects major, significant barriers to donation.[229] These conclusions were echoed more recently in a Canadian transplant surgeon's observations that "[a]lthough barriers exist at each step of the donation process, the major ones occur within the health care system primarily because of a reluctance of the medical community to approach families of potential donors for consent."[230]

Clearly, the tragic side of the life-from-death reality of current Canadian organ procurement and donation practice weeps ambivalence. The ambivalence is a major contributing factor with regard to the current scarcity of available organs.[231] Only 10 to 20 per cent

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226. Nolan and Spanos, *supra*, note 225 at 27. In a recent U.S. survey, "the two most common reasons given for not permitting organ donation were (1) they might do something to me before I am really dead; (2) doctors might hasten my death." Judith Areen, "A Scarcity of Organs" (1988) 38 J. Legal Educ. 555 at 562, discussing report of U.S. Task Force on Organ Transplantation.

227. See Helen Levine Batten and Jeffrey M. Prottas, "Kind Strangers: The Families of Organ Donors" (1987) 6:2 Health Aff. 35. See also chap. 4, below.

228. FEDS, *supra*, note 29 at 95.

229. ONT, *supra*, note 29 at 97 (identifying failure to identify suitable donor and failure to initiate donation process as medical barriers to procurement); *Report of the Alberta Human Tissue Procurement Task Force*, *supra*, note 143 at 18 ("The most significant barrier to obtaining organs and tissue for transplantation is thought to lie within the medical profession itself. For whatever reason, medical staff appear reluctant to counsel organ donation."). See also *Review of Organ and Tissue Donation and Transplantation in Saskatchewan* (Regina, Sask.: Ministry of Health, 1987) at 62, 65.

230. Robinette, *supra*, note 225 at 72.

231. See generally Jeffrey M. Prottas and Helen Levine Batten, "Health Professionals and Hospital Administrators in Organ Procurement: Attitudes, Reservations and Their Resolutions" (1988) 78:6 Am. J. Pub. Health 642. See also ONT, *supra*, note 29 at 97.

of potential organ donors currently become actual donors.[232] Yet, the federal-provincial transplant task force has concluded that a sufficient supply of organs is "potentially available" if the organs can be procured.[233] What means, if any, then, should society invoke to cultivate attitudes and practices favourable to donation to help overcome the organ donation shortfall? Massive public education and professional training? Increased incentives? Modest coercion? May the law contribute to resolving the undeclared donor scenario, as has been suggested in other countries? To answer such questions requires an examination of the ethical and legal infrastructure in which tissue procurement and transplantation take place.

232. Robinette, *supra*, note 225 at 69 (10%); ONT, *supra*, note 29 (10%); Darby et al., *supra*, note 192 at 2222 (15%-20%).

233. FEDS, *supra*, note 29 at 95.

CHAPTER TWO

The Ethics of Tissue Procurement

If medicine fashions the tools for remaking the human body, ethics helps fashion the moral contours for their use. Tissue replacement technologies offer newer means for acting on the long-cherished ethical value of saving life. Society understandably welcomes these advances. Saving life is not alone, however, amongst core societal values. How we structure the tissue procurement process — how we go about saving life — might prove important, if only because these techniques, machines and technologies provoke moral choice, to be made in light of new practices, ways of living and ways of thinking about life, death, the human body and physical and spiritual existence. For all their novelty, these highest of technologies still do little to quell our enduring need to live in harmony with and comprehend the moral import of the very tools we create.[234] Ethics addresses this constant dimension of humanity, by allowing us to see how some of the tools, practices and eventual policies touch diverse and sometimes competing human values.

As such, moral inquiry into tissue procurement policy involves the basic tasks of applied bioethics: (1) identifying underlying values; (2) weighing values that conflict or compete; and (3) choosing a course or policy that implements priorities assigned to competing values.[235]

The values of autonomy, non-maleficence and beneficence figure prominently in current biomedical and transplant ethics.[236] Autonomy enables individuals to direct their lives according to their own interests and goals. To secure consent before procuring a person's organs for transplantation is to respect the person's autonomy. Non-maleficence requires that one not harm others, while beneficence encourages one to benefit others.

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234. See Laurence H. Tribe, "Technology Assessment and the Fourth Discontinuity: The Limits of Instrumental Rationality" (1973) 46 S. Cal. L. Rev. 617 ("There remains, it is said, a fourth great discontinuity — that between man and his machines — which must be bridged if man is to live in harmony with his tools, and hence with himself").

235. See Terrence F. Ackerman, "What Bioethics Should Be" (1980) 5:3 J. Med. Phil. 260, 261.

236. See Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 3d ed. (New York: Oxford University Press, 1989). Justice, another prominent bioethical principle, aims at a fair distribution of social benefits and burdens. Because the focus of the immediate inquiry centres on procurement, the pressing challenges of allocating scarce tissue and medical resources are not generally explored here. Compare James F. Childress, "Some Moral Connections between Organ Procurement and Organ Distribution" (1987) 3 J. Contemp. Health L. Pol'y 85.

Consulting the relatives of recently deceased individuals about tissue procurement may avoid harm, by not treating the body of a loved one offensively. Tissue transfers may also advance beneficence by helping to save the lives of transplant recipients.

Resolving the value conflicts in tissue procurement practices may sometimes prove more difficult than identifying them. How much importance, for example, should be assigned to saving life, if the tissue procurement process used overrides fundamental religious beliefs? The conclusion that life and health preservation prevails over other values might lead policy makers to opt for a policy of routine procurement. Yet, if respect for the wishes of surviving relatives is deemed paramount, procurement conditioned on the consent of relatives might be preferred. The choices are difficult because the values in conflict do not reduce to common denominators, despite a desire to prioritize them for ethical choice. The value orderings that are ultimately chosen need not be absolute, however. Some analysts emphasize the possibility of arriving at compromise policies that balance important and competing values in the procurement process.[237]

This framework of analysis — identifying and attempting to weigh and prioritize competing values — is used to explore the following tissue procurement questions:

— What is the moral basis of the prevailing model for organ donation, as compared with possible alternatives?

— Since transplantation depends largely upon organs recovered from the dead, how do moral considerations such as respect for persons, protecting bodily integrity and promoting human dignity apply to the treatment of dead bodies?

— What are the moral arguments for and against the sale of human tissues?

— What are the ethical implications of regarding human bodies as property?

Section I thus examines the giving and taking of cadaveric tissue and the ethical meaning of "harm" to the dead. Section II discusses the ethics of tissue procurement from living adults, children[238] and mentally disabled persons. Section III looks at moral duties to donate. The final section explores the relation between our physical bodies and notions of self, with respect to various tissue procurement practices, bodily property and human tissues sales. At least one clear conclusion emerges from the discussion: competing views of the body-self relation strongly influence, and often determine, the moral assessment of particular tissue procurement proposals and practices.

I. Deceased Donors

To help save life, how should society obtain the therapeutic human tissues of the recently deceased? Shall we procure them routinely and efficiently? Or, is a community

237. See David A. Peters, "Protecting Autonomy in Organ Procurement Procedures: Some Overlooked Issues" (1986) 64 Milbank Mem. Fund Q. 241 at 263, and David A. Peters, "Required Request: A Practical Proposal for Increasing the Supply of Cadaver Organs for Transplantation" (1985) 84 Wis. Med. J. 10 at 12.

238. For a discussion of anencephalic infants as organ "donors," see chap. 3, section II.B, below.

of givers preferable to a community of takers? The simple extremes of pure giving and taking may be slightly abstracted from social reality. But exploring them places in sharp relief the moral foundations, philosophical disputes and competing values embedded in societal tissue transfer policies, which range from pure altruism to routine procurement.

A. Altruism — Giving Is Better Than Taking

The word "donation" is virtually synonymous with human tissue transfers in Canada.[239] Donation derives from the Latin word for gift.[240] Altruism, the unselfish concern for the welfare of others,[241] is often invoked to explain motivations for the giving.

Proponents typically offer three general reasons to support the gift ethic formalized in national blood policy principles and Canadian tissue transfer law.[242] These are that altruistic tissue transfers nurture community bonds and generosity, accord respect that is due the dead human body and avoid the perceived ills and risks of routine procurement policies. The first reason appeals to the kind of society that many might prefer:

> A society will be a better human community in which giving and receiving is the rule, not taking for the sake of good to come. The civilizing task of mankind is the fostering, the achievement, or the shoring up of consensual community in general, and not only in regard to the advancement of medical science and the availability of cadaver organs in efforts to save the lives of others. Civilization means living our consensual communities, not living in communities in which consent and refusal go on, just as surely as we live our bodies, not in them. The positive consent called for by Gift Acts, answering the need for gifts by encouraging real givers, meets the measure of authentic community among men. The routine taking of organs would deprive individuals of the exercise of the virtue of generosity.[243]

So conceived, donated human tissues become the material and symbolic gifts of life that bond strangers in our communities.[244]

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239. The language and vernacular of the tissue transfer process reflects moral precepts, which echo in the titles of substantive articles on the subject. See, *e.g.*, Alfred M. Sadler and Blair L. Sadler, "A Community of Givers, Not Takers" (1984) 14:5 Hast. Cent. Rep. 6. See also David Helwig, "Organ Procurement: Coercion or Informed Consent?" (1988) 139:1 C.M.A.J. 59 ("'But . . . .' the father countered, 'I heard somebody talking about harvesting. I'm a farmer. I know what harvest means, and I don't want any part of that, where we tear the cob of corn from the stalk and don't care about the stalk. I care. That's my boy.'"). Some regard the official ideology of tissue procurement as "both too simple and too sentimental." R.C. Fox, "Organ Transplantation: Sociocultural Aspects" in Warren T. Reich, ed., *Encyclopedia of Bioethics*, vol. 3 (New York: Free Press, 1978) 1166 at 1168. For an anthropological discussion of the norms that structure the exchange of gifts, see Marcel Mauss, *The Gift: Forms and Functions of Exchange in Archaic Societies*, trans. I. Cunnison (London: Cohen & West, 1969).

240. J.B. Sykes, ed., *The Concise Oxford Dictionary*, 7th ed. (Oxford: Clarendon Press, 1982) at 285.

241. *Ibid.* at 26.

242. See chap. 3, section III.B, below.

243. Paul Ramsey, *The Patient as Person: Explorations in Medical Ethics* (New Haven: Yale University Press, 1970) at 210.

244. See Richard M. Titmuss, *The Gift Relationship: From Human Blood to Social Policy* (London: George Allen & Unwin, 1970). See also Roberta G. Simmons, Susan Klein Marine and Richard L. Simmons, *Gift of Life: The Effect of Organ Transplantation on Individual, Family and Societal Dynamics* (New Jersey: Transaction, 1987).

A second reason for favouring altruism turns on the role of the body in our understanding of what it means to be a person. Under one view, persons are seen as inseparable from their bodies. Consequently, the dignity of the human body is inseparable from the dignity of the person.[245] This nexus survives death, because the body then symbolizes the person who once lived:

> Admittedly the corpse is no longer a man. The cadaver is a kind of shroud that now masks rather than expresses the soul that once animated it. And yet — while the body retains its recognizable form, even in death, it commands a certain respect. No longer a human presence, it still reminds us of that presence which once was utterly inseparable from it.[246]

Moreover, if we associate the value of human dignity with the value of autonomy, then a tissue transfer system that respects wishes — to donate or not — that take effect after death may seem more accommodating of those values.

A third reason suggested in favour of a system of giving is that, beyond promoting altruism and accommodating such values as autonomy, it is more likely than other alternatives to constrain harmful attitudes and abusive practices. For example, some people object to routine procurement because they perceive it as more likely to foster negative attitudes that reduce both deceased and living human beings to an assembly of interchangeable spare parts.[247] The concern again centres on how procurement systems affect how we think of our physical and moral selves. To be seen as a living "spare parts pre-cadaver," or medical commodity, risks demeaning individuality and human dignity by reducing human beings to potential physical instrumentalities of well-intended biomedical science.

Another concern is that routine procurement is likely to alter the patient-provider-hospital relation. It may cast the hospital into the role of the taker-"devourer," obscure its traditional role of care giver and provider of "the healing mission"[248] and thus erode the trust upon which the healing arts so depend. Indeed, Canadian and American studies have documented the public's distrust and fear about premature organ procurement.[249] Like concerns about dying patients being perceived as containers of spare parts and concerns about disrespecting the dead, the distrust seems somewhat generic to transplantation. Ethically and legally questionable research and medical teaching interventions on mechanically maintained dead patients, for example, have occurred in different procurement systems.[250] If it cannot be shown that one system significantly decreases or increases the likelihood of such concerns arising, they may be inherent to both the donation and taking of organs.

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245. William F. May, "Attitudes toward the Newly Dead" (1973) 1:1 Hast. Cent. Stud. 3. See also William F. May, "Religious Justifications for Donating Body Parts" (1985) 15:1 Hast. Cent. Rep. 38 at 39.

246. May (1973), *supra*, note 245 at 3. See also May (1985), *supra*, note 245 at 39-40.

247. See Ramsey, *supra*, note 243 at 209 ("everyone a useful precadaver").

248. See May (1973), *supra*, note 245 at 6.

249. See James F. Childress, "Ethical Criteria for Procuring and Distributing Organs for Transplantation" (1989) 14:1 J. Health Pol. Pol'y L. 87 at 91-92. See *supra*, note 226.

250. For a discussion of recent practices, some of which have provoked criminal charges, in both express- and presumed-consent countries, see chap. 3, below. See also Willard Gaylin, "Harvesting the Dead" (1974) 249 Harper's 23 at 26 (describing bioemporiums, where the mechanically maintained dead are used for teaching, research and transplantable tissues); and Paul Taylor, "MDs Ponder What to Do with Up to 10,000 'Living Dead'" *The [Toronto] Globe and Mail* (23 August 1989) A1.

The expression of these ideals and fears indicates a basic difficulty experienced by proponents of altruism, as pressing medical needs increasingly challenge the underlying theories and daily consequences of pure altruism. In the extreme, the tension pits intangible moral, emotive concerns against the tangible, more quantifiable benefits of increased tissue supplies.

For example, while the blood donation system seems to work, only a minority of individuals actually takes steps to donate organs after death.[251] Even if a community of tissue givers is morally preferable to a community in which tissues are taken, persistent tissue scarcity nudges society to ask how strong the preference is for giving. Might not other less costly venues permit the exercise of generosity[252] and the building of a consensual community while reducing transplant waiting lists? Does the minority, who exercises generosity by donating organs, sufficiently enhance the overall moral and physical good of the community to justify not altering the procurement system?

The moral good of altruism is not easily measurable. Altruism, as envisaged, does not necessarily mean enlightened acts of free will. To use a popular phrase, it is "encouraged voluntarism." Those unwilling to contemplate death and organ donation are encouraged to do so through societal laws and practices.[253] Some consider that the intangible benefits flowing from the opportunity offered by altruism for moral enlightenment in the community are more important than transplant benefits.[254] But what are the specific intangible benefits that need to be weighed against the material benefits of more tissues for transplant? Broad altruistic appeals do not pinpoint the specific values that compete with preserving life, nor do they explain why those values are more important than routinely prolonging life.

In short, if the ideal of unfocused generosity remains elusive, can we not satisfy immediate human needs in other ways? What alternative policies for procuring cadaver organs are morally viable, if the ideal of an "authentic community" either cannot be measured and attained or exacts too high a price in terms of human lives and suffering?

B. Routine Procurement — Taking Is Better Than Giving

The tension between immediate quantifiable medical needs and the less measurable, perhaps more symbolic, attributes of altruism leads some ethicists to propose the routine procurement of tissue from the dead. For them, the choice is between "interest or life on one side and symbolism and sentiment on the other."[255] Once the competing values are couched in these terms, symbolism loses:

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251. See text accompanying note 226, above.

252. See James L. Muyskens, "An Alternative Policy for Obtaining Cadaver Organs for Transplantation" (1978) 8 Phil. Pub. Aff. 88 at 96.

253. See Ramsey, *supra*, note 243 at 210.

254. See *ibid.* at 210-11.

255. Joel Feinberg, "The Mistreatment of Dead Bodies" (1985) 15:1 Hast. Cent. Rep. 31 at 32.

> On the one side of the scale is the saving of human lives; on the other is the right of a person ... by the use of a symbolic ritual to convert his consent into a genuine 'gift'. Even in this extreme confrontation of interest with symbol, ... [proponents of the giving of organs accord] the symbol more weight. If the subject were not itself so grim I might be tempted to charge [them] with sentimentality.
>
> ... [B]alancing tests ... dictate that appeals to interest ... have greater weight and cogency than appeals to offended sentiment, and should take precedence when conflict between the two is unavoidable.[256]

The critique is that the naked sentiment evoked by a dead human body, for example, promotes emotional indulgences that either distract from true ethical deliberation or obscure pre-eminent interests. As one critic suggests, "[t]he error consists of attaching a value to a symbol, and then absorbing oneself in the sentiments evoked by the symbol at the expense of real interests, including the very interests the symbol represents."[257] Such critics concede that "social utility" may be promoted by "widespread respect for certain natural symbols," but conclude that this "real but diffuse value would be outweighed" whenever genuine interests are at stake.[258] If sentiments attach to genuine values, these values still lose in competitions with interests, apparently because the values prove too "diffuse."

In many respects, the debate about procuring organs thus reflects a more fundamental debate. On one side is the prevailing philosophical school, which regards morality as a rational enterprise with little place for non-rationality. Emotions acquire a determinate focus through images and symbols. This rationalist school worries that the link between emotion, values and symbolism is, at least, morally distracting and, at most, morally destructive of other values or interests that are thought to be pre-eminent. On the other side is a view that lived morality is embedded in the customs, traditions and beliefs of particular communities and is expressed through symbols and sentiments as well as reason.[259] This school worries that the greatest moral danger in our technological society is "devaluing feeling and not attending to or nurturing moral emotions."[260] The ethics of tissue procurement thus becomes an arena for a basic philosophical dispute over practical morality.

Having identified the depths of the dispute, what can we say of the role of emotions in morality? It does seem self-evident that correct moral choices are not simply or consistently inspired by emotion and symbolism. Rational deliberation is undoubtedly a

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256. *Ibid.* at 32.

257. *Ibid.* If the "mistake" lies in detaching interests from the sentiments symbols evoke, then even naked sentiments may possess legitimate values, as registered by any interests they may ultimately reflect. The "mistake" might be rectified by identifying the interest associated with sentiment and pitting it against the "real interest" on the other side.

258. *Ibid.*

259. May (1985), *supra*, note 245 at 38 ("Academic ethicists working on the subject of organ transplants usually appeal to reason alone, uninformed by religious tradition or by the communities that, however imperfectly, embody those traditions").

260. Sydney Callahan, "The Role of Emotion in Ethical Decision-Making" (1988) 18:3 Hast. Cent. Rep. 9 at 12.

prime ingredient. However, two reasons may raise doubt about its being the only legitimate ingredient. First, those dismissive of sentiment provide no coherent, compelling argument for categorically purging emotion from the debate and uniformly preferring interests over sentiments. Their most compelling critique aims at some of the quantifiable consequences of routine giving. The critique is conveyed through consequentialist examples that impart their own symbolic appeal. One example counterposes the non-use of a newly dead body against untold medical benefits presumed to derive from autopsies and research on cadavers.[261] Does the recently deceased patient symbolize a human being, represent untold potential research benefits or symbolize and represent both?

Secondly, in the absence of a more affirmative, coherent theory, the strict rationalist view tends to become absolutist, detached and unheeding of the potential moral insights that may be born of the rational-irrational deliberation evoked by human experience in diverse communities. If an interest basis for rejecting a tissue procurement proposal is not articulated, the emotive argument that a practice is too repugnant will not be heard to convey a moral message; nor will it outweigh the benefits presumed to arise from procurement.[262] A more tempered view about the role of emotions in moral decision making might broaden the field of acceptable ethical choice beyond the confines of strict rationalist morality.

Thus, if writers who have regard for symbols and sentiment may be criticized for overly indulging the moral force of emotion and for having difficulty measuring the moral benefits of pure altruism, they would still seem more accommodating of diverse moral values and options. The preference for altruism is not absolute. Its proponents find neither the routine giving nor the taking of cadaver organs inherently wrong,[263] but insist that giving be tried first: "[H]uman attitudes toward death (and the newly dead) are such that a system of organized giving must be granted a serious test before entertaining the alternative of routine salvaging."[264] In essence, these writers recognize a range of disparate values relevant to transplantation. They prefer a procurement policy that tries to accommodate those values. Their conclusion is comparative: "[T]o foster the organized giving of cadaver organs is preferable to the routine use of organs by hospitals."[265]

The difference between these competing schools of thought may suggest a path out of the underlying philosophical impasse. The dispute over the giving and taking of cadaver organs does arise from disagreements about what legitimate values need to be considered and how much weight should be given to inconsistent values. The disagreements, in turn, spring from deeper sources: differing views about the nature of morality and about the

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261. Feinberg, *supra*, note 255 at 32. Query: Would the appeal to preventing "thousands" of unknown illnesses and deaths be as enticing if we were able to read the protocol and determine how likely or how speculative the benefits to be derived from this particular cadaveric research were?

262. See *ibid.* at 33.

263. Ramsey, *supra*, note 243 at 208.

264. May (1973), *supra*, note 245 at 4.

265. Ramsey, *supra*, note 243 at 209.

relation between persons and their bodies. Yet, both schools assign great importance to the value of preserving life and health. They dispute its precise weighting. The exchange of views suggests that the underlying philosophical bind might be relieved by deciding whether a policy of giving has received a fair test. If so, its proponents would seem willing to move towards the routine taking of cadaver organs. If not, then competing legitimate values require, in their view, that we persevere in and reform the system of giving, to improve its yield of therapeutic tissues.

C. Giving, Taking and Harming the Dead

Lingering through this discussion, but rarely openly addressed, is the question of how or whether the dead can be "harmed." Some, in an attempt to allay the moral misgivings of transplant professionals, claim that "it is impossible to inflict personal harm on a dead patient."[266] Are dead persons, in fact, harmed when doctors in training practice non-consensual interventions on their bodies, or when they are used for unauthorized research?[267] If so, what is the nature of the harm? An infringement of autonomy? A violation of human dignity? A moral wrong to the community?

One way in which the dead seem unlikely to be harmed is by the violation of their autonomy. Moral autonomy allows persons to direct their lives according to their own values and to protect themselves from what they regard as harm and exploitation. Obviously, dead persons have no lives to superintend. Strictly speaking, the functions of autonomy are no longer relevant to the cadaver, then, because the dead have no moral autonomy.[268]

Can the dead be harmed by having their interests infringed? The same logic would seem to apply. According to a dominant rationalist view, rights are attributed only to persons who have interests. Interests "must be compounded somehow out of wants and purposes, both of which in turn presuppose something like expectation, belief, and cognitive awareness."[269] In this view, then, the dead, who no longer possess these attributes, have no interests and, since rights are predicated upon interests, would also have no rights that might be violated.

According to another view, however, this conclusion cannot be drawn:

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266. See Stuart J. Youngner et al., "Psychosocial and Ethical Implications of Organ Retrieval" (1985) 313:5 N. Engl. J. Med. 321 at 323.

267. See chap. 3, section II.C(3), below, and *Arnaud* v. *Odom*, *infra*, note 872.

268. Albert R. Jonsen, "Transplantation of Fetal Tissue: An Ethicist's Viewpoint" (1988) 36:3 Clinical Research 215 at 219; Russell Scott, *The Body as Property* (New York: Viking Press, 1981) at 260 ("Certainly the dead must be respected, . . . but the dead body is a thing utterly different from the living body. The very idea of applying the notion of personal autonomy to a corpse is absurd; at most, personal autonomy is only artificially extended beyond death."). But see ALRC, *infra*, note 1010.

269. Joel Feinberg, "Is There a Right to Be Born?" in James Rachels, ed., *Understanding Moral Philosophy* (Encino, Calif.: Dickenson, 1976) 346 at 349.

> [D]ead persons can have rights against us, namely rights to the fulfillment of promises made to them when they were alive, and rights not to be falsely defamed to those who once knew and loved them. This admittedly paradoxical conclusion is supported by the idea that certain of a dead person's interests can be thought to survive their owner's death and constitute claims against us that persist beyond the life of the claimant. This in turn requires us to think of interests as fulfilled only by the coming into existence of that which is desired, and not simply as "satisfaction of desire" in the sense of contentment in the mind of the desirer when he believes that his desire has been fulfilled.[270]

In this analysis, certain interests survive a person's death and generate rights. These are usually restricted to "their interests in a good reputation, proper disposal of their worldly possessions, and considerate handling of their corpse."[271]

This view has intuitive appeal but suffers from certain limitations. It lacks a theoretical account of how the dead have interests. Moreover, it does not provide a specific account of how select interests survive death. Rather, there is only an appeal to the distinction between fulfilling and satisfying desires. Since interests are products of subjective states of mind, such as desires, it does make some sense to talk about our desires or interests being fulfilled after death. The knowledge that our wishes will be respected after death may well give us a fuller sense of personal autonomy. It would also seem to impart a greater sense of peace in the preparation for and contemplation of death. Thus, the utter disregard of one's[272] burial wishes, or the failure to honour one's express wishes on the post-mortem use of one's body, lend credence to the claim that people have interests that survive their deaths and that they may be harmed when the interests are violated.[273] What remains refractory is providing a coherent philosophical explanation of this intuition.

What of broader notions of harm that encompass potential moral wrongs such as indecent treatment of the dead or acts that violate human dignity? Morality, after all, encompasses more than the duty not to harm. It has been suggested, for instance, that it would be unjust to refuse to confer an award or bestow an honour because the person who qualified for it has died. In this view, merely fulfilling the conditions for an award entitles one to it; one need not "be able to personally claim it, to be in fact entitled to it and have a right to it."[274] Similarly, a failure to dispose of property as set forth in a will might be morally wrong because it is unjust, even if contravening the will of the decedent cannot be said to harm the decedent. General strictures of morality, notably requirements of justice, might therefore preclude certain actions with respect to the dead.[275]

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270. *Ibid.*

271. Raymond A. Belliotti, "Do Dead Human Beings Have Rights?" (1979) 60 Personalist 201 at 208. For a list of possible rights of the dead, see *ibid.* at 209.

272. See Peters (1986), *supra*, note 237 at 254.

273. See George Pitcher, "The Misfortunes of the Dead" (1984) 21:2 Am. Phil. Q. 183 ("If we allow our unfettered intuition to operate on certain examples, it becomes abundantly clear that we think the dead can indeed be wronged").

274. Belliotti, *supra*, note 271 at 206.

275. See Childress, *supra*, note 249 at 98 (People may be wronged when their wills are thwarted). Yet, wronging implies that there still are subjects of a wrong, which seems problematic when applied to the dead.

Embedded in these notions of potential moral wrongs is a premise that dead bodies deserve moral protection by virtue of their symbolic function. This view is especially prevalent in religions that demand respect for the dead body in the belief that both living and dead human beings are created in the image of God; thus, for example, "Jews and Christians respect the body of the dead as symbolic of the human person and his dignity."[276] In this view, acts disrespectful of the dead may contravene religious beliefs and constitute symbolic moral wrongs in the community sharing these beliefs, by violating concepts of human dignity that seem wedded to the body even after death. Whether such potential moral wrongs constitute harms would appear to be definitional.[277]

Of course, any such concepts of wrong or harming will be challenged, or perhaps redefined, by competing views and values. We have seen that the ethical role and emotive force of symbols in practical morality provoke deep philosophical debate. Proponents of rationalist morality warn against respecting symbols "too much."[278] The warning extends to the moral status of the recently deceased patient:

> A dead body is no longer a person. Even though corpses must be respected because they were once living persons, the obligation of respect has less force than when it is applied to living persons. In the case of intubating newly dead bodies, the respect is limited to avoiding disfigurement or ridicule of the cadaver.[279]

The high, and perhaps increasing, medical value placed on use of the human body means that any competing emotive, religious or symbolic values associated with protecting the dead must be weighed against the medical interests of the living.[280] The tendency of the medical interests to be more tangible, quantifiable and immediate may suggest that the more emotive, ethereal and symbolic values will not fare well in competition with those interests. What is needed in these conflicts is a comparative appraisal of the specific competing interests and values. If making that particularized judgment is a task not amenable to easy philosophic resolution, the judgment nevertheless remains the crux of the moral controversy over the supply of cadaver tissue.

II. Living Donors

What restrictions does morality impose upon the acquisition of organs from living persons? For competent adults, the value of respecting autonomy would seem to preclude

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276. White, *supra*, note 91 at 138-39.

277. Joel Feinberg, "Sentiment and Sentimentality in Practical Ethics" (1982) 56 Proc. Addresses Am. Phil. A. 19 at 20 ("[I]ndignation can achieve red hot intensity when there is no harm produced at all, but only disrespect shown to some precious symbol, like a flag or a cross").

278. Feinberg, *supra*, note 255 at 31.

279. James P. Orlowski, George A. Kanoti and Maxwell J. Mehlman, "The Ethics of Using Newly Dead Patients for Teaching and Practising Intubation Techniques" (1988) 319:7 N. Engl. J. Med. 439 at 440 (arguing for medical use of the newly dead without consent of surviving family members).

280. Belliotti, *supra*, note 271 at 207-08.

taking without the person's consent. For incompetent individuals lacking personal autonomy, the situation is less clear. Does treating children and mentally impaired persons differently than competent adults exploit their incompetence and vulnerability, or is it morally justified?

A. Adults

Under modern bioethical theory, the functions of consent in medical treatment include the promotion of individual autonomy and the protection of the patient from harm.[281] Consent alone, however, does not ensure the moral acceptability of the medical intervention. Commonly accepted biomedical principles also suggest that the donor should gain from the sacrifice, through the prevention of foreseeable harm or the acquisition of benefit.[282] In some instances, even consent and the bare prospect of preventing harm may not ensure moral acceptability, because those conditions alone arguably countenance a living father's donation of his heart to save his son:

> [T]he self-giving of hearts may well meet the test of consent alone, if this is the necessary and a sufficient right-making feature. . . . If need be, the self-giving of hearts can also meet the "prevention of detriment" test — the detriment of suffering a son's death judged to be more unbearable than one's own — or it can meet the "spiritual benefits" test.[283]

Such a donation is morally unacceptable, because it violates the bodily integrity and results in the death of the donor.[284]

Hence, a third condition, risk-benefit appraisal, is required to protect the values associated with a donor's bodily integrity.[285] Under one formulation, tissue transplants are morally justified when (1) the risk to the donor is "very much less" than the potential benefit to the recipient, or (2) "the objective benefit" to the recipient "heavily" outweighs the loss to the donor.[286] The nature of the physical risks to the donor depends largely on the tissue to be donated and the state of the art of the transplant procedure. Blood, sperm, bone marrow[287] and kidney donation involve varying degrees of risk, surgical invasiveness and irreversibility. One estimate made some twenty-five years ago compared

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281. See Beauchamp and Childress, *supra*, note 236 at 76, discussing A.M. Capron, "Informed Consent in Catastrophic Disease and Treatment" (1974) 123 U. Pa. L. Rev. 364. See also Jay Katz and Alexander Morgan Capron, *Catastrophic Diseases: Who Decides What?* (New York: Russell Sage Foundation, 1975) c. 6 at 79.

282. See Beauchamp and Childress discussing non-maleficence, *supra*, note 236 at 120.

283. Ramsey, *supra*, note 243 at 190.

284. See *ibid.* See also Beauchamp and Childress, *supra*, note 236 at 370.

285. See Beauchamp and Childress discussing beneficence, *supra*, note 236 at 194. See also Ramsey, *supra*, note 243 at 195 ("Bodily integrity must be a norm operating in the assessment of the morality of the self-giving of organs, even if it is outweighed").

286. Ramsey, *supra*, note 243 at 195.

287. See *Reassessment of Autologous Bone Marrow Transplantation*, *infra*, note 534 at 2.

the risks of kidney donation with the risks of injury or death associated with commuting sixteen miles a day,[288] and found that the "figures seem to offer the opportunity of a reasonable sacrifice."[289]

Thus, three conditions emerge for the permissibility of using organs from the living: (1) the donor must consent freely and knowledgeably; (2) there must be some reasonably expected benefit to the donor; and (3) likely benefits to the recipient must considerably outweigh likely harms to the donor. If we accept these, can any of these conditions ever be waived or overridden as, for example, with children and mentally disabled persons?

B. Children and Mentally Disabled Persons[290]

Some courts have approved tissue procurement from children and incompetent adults without strict adherence to all of the above conditions.[291] Why are they treated differently? What should happen to these ethical requirements, if the potential donor is incapacitated by reason of age or mental disability? If incompetency and vulnerability do not dictate a ban on procurement from such persons, on what moral grounds may it proceed?

A ban on using children and mentally handicapped persons as organ donors could rest on three grounds.[292] First, one may insist that the requirement of patient consent be applied to all bodily intrusions. When a person lacks the legal capacity to consent, no valid consent can be had and hence no violation of bodily integrity is justified. Secondly, a flat prohibition may be urged on the grounds that children and mentally disabled persons are sought as organ donors, as some have claimed, because "what often happens inside a family, and outside, is a balancing of social worth, whether consciously or not."[293] Thirdly, one may argue that the ethical requirement of patient benefit lies unfulfilled, because vulnerable donors receive neither physical nor putative psychological benefits from sacrificing their tissue.

These concerns parallel the major concerns in the ethics regarding the use of children and mentally disabled persons in medical research for which they receive no discernible benefits.[294] Insisting upon consent from individuals who lack the capacity to consent effectively bars non-therapeutic medical research, even if it offers protections to vulnerable

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288. Ramsey, *supra*, note 243 at 177, citing J.P. Merrill, "Letters and Comments" (1964) 61 Ann. Internal Med. 356.

289. *Ibid.* at 196. The improved surgical techniques and cumulative experience of the last 25 years suggest donor risks are even less today.

290. For a discussion of anencephalic organ donors, see chap. 3, section II.B, below.

291. See *infra*, notes 300, 302. See also Scott, *supra*, note 268, c. 5 at 101.

292. Scott, *supra*, note 268 at 122.

293. *Ibid.*

294. Compare MRC, *supra*, note 118 at 28-32, and Barry Hoffmaster, "The Medical Research Council's New Guidelines on Research Involving Human Subjects: Too Much Law, Too Little Ethics" (1989) 10 Health L. Can. 146.

persons.[295] Banning such research may also condemn other vulnerable persons to continue to be afflicted with diseases that can only be conquered by further research. With organ donation, although the potential harms of a comparable prohibition may not be as extensive in society, they would, in individual cases, be just as severe.

Requiring consent from the incompetent may also be misplaced. If consent functions primarily to protect autonomy, and those lacking the legal capacity to consent by definition already lack autonomy,[296] then imposing a requirement of donor consent fails to effect its underlying rationale. This is not to deny the moral function of securing consent from mature minors or from a potential donor's relatives or guardians. Mature minors may possess the autonomy that consent helps protect. Moreover, it is obviously desirable to defend incompetent, vulnerable individuals by having someone concerned about their welfare make an independent appraisal of risks and benefits. An independent assessment or proxy consent requirement may thus protect incompetent patients from harms, check fraud and duress and encourage self-scrutiny by medical professionals.[297]

If a potential tissue donor lacks the autonomy to exercise consent, on what alternative moral grounds might tissue procurement be based? As with competent individuals, the value of beneficence suggests that donation might be justified if reasonably foreseeable benefits to the donor offset likely harms. This donor-centred perspective helps ensure that organs are not taken from individuals who cannot speak for themselves. Focusing the harm-benefit appraisal on genuine benefits also diminishes the risk that the appraisal may be used to mask biases about the incompetent individual's being of less social worth.

Can children and mentally handicapped persons legitimately be said to benefit from sacrificing organs? While strong scepticism[298] or a rebuttable presumption[299] against such procedures might help to police ulterior motives, the argument for donation to prevent net harm is still compelling in particular cases. For example, a Quebec court recently authorized a five-year-old to donate bone marrow to his brother ill with cancer.[300] In the early days of kidney transplants, Massachusetts courts authorized donations between minor twins.[301] In one of the leading cases on psychological donor benefits, a court in the United States weighed the harms and benefits involved in a mentally impaired person's donation of a kidney to his brother, and concluded that the donor's "well-being would be jeopardized

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295. See LRC, *Biomedical Experimentation Involving Human Subjects*, Working Paper 61 (Ottawa: The Commission, 1989) at 40-42 (recommending federal statute to govern non-therapeutic medical research on children).

296. See MRC, *supra*, note 118 at 28 ("By definition, a legally incompetent subject is not autonomous, and cannot give a legally or ethically valid consent").

297. See Capron, *supra*, note 281.

298. See Ramsey, *supra*, note 243 at 172.

299. Rodney K. Adams, "Live Organ Donors and Informed Consent" (1987) 8 J. Legal Med. 555 at 582.

300. See *Cayouette et Mathieu*, *infra*, note 380.

301. William J. Curran, "A Problem of Consent: Kidney Transplantation in Minors" (1959) 34 N.Y.U. L. Rev. 891.

more severely by the loss of his brother than by the removal of a kidney."[302] Thus, concentrating on an expansive view of human existence in risk-benefit appraisals may yield outcomes that differ substantially from those that flow from an exclusive focus on the physical person.

To suggest, as these cases do, that psychological benefits are morally relevant,[303] however, does not say to what degree putative psychological benefits might count. Risk-benefit appraisals must be addressed in concrete situations. Disagreement about whether this can be done helps distinguish those who would permit organs to be taken from children and mentally handicapped persons from those who would not. In moral terms, the difference is that the former group takes a contextualist approach and the latter group, a principled approach. In law, it is the difference between equity and strict application of rules.[304]

Advocates of the former approach have confidence in the ability of human beings to discern what is right or best in particular idiosyncratic circumstances. Thus, some analysts regard transplant cases decided on psychological-benefit theories as "judgements ... characterized by humanity and compassion rather than blind adherence to one principle or test."[305] Others disparage psychological-benefit theories as a speculative and unreliable standard[306] dependent on situation ethics and palm-tree justice. In their view, general principles or rules need to be applied uniformly to avoid the evils of bias and subjectivity. They hold that consistency is the hallmark of both principled morality and the rule of law and must be observed even if it results in uncompassionate or unfair outcomes in some cases. With respect to taking organs, therefore, they insist that children and mentally disabled persons be treated the same as adults. Once again, a tissue transfer conflict springs partially from a fundamental philosophical dispute.

III. A Moral Duty to Donate

If ethical values, such as autonomy and non-maleficence, work negatively to shield our bodies from non-consensual, harmful interventions to obtain tissue, do they also work positively to obligate us to donate tissue? The prevailing North American model of altruism

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302. *Strunk* v. *Strunk*, 445 S.W. 2d 145 at 146 (Ky 1969). But see *In re Guardianship of Pescinski*, 226 N.W. 2d 180 (Wisc. 1975) (denying authorization for incompetent adult chronic schizophrenic mental patient to donate kidney to sister), as modified by *Re Guardianship of Eberhardy*, 307 N.W. 2d 881 at 893 n. 13 (Wisc. 1981). These cases were recently discussed in *Curran* v. *Bosze*, *infra*, note 535 at 1326-29.

303. See MRC, *supra*, note 118 at 7 ("The harms that may be incurred are legion and include ... loss of dignity and self-esteem, guilt and remorse, or feelings of exploitation and degradation"). If psychological harms are morally relevant to, and may count against human subjects participation in non-therapeutic medical research, might not psychological benefits count in favour of donation?

304. See *The Nicomachean Ethics of Aristotle*, 1925, trans. Sir David Ross (reprinted London: Oxford University Press, 1966) Bk. V, c. 10.

305. Scott, *supra*, note 268 at 121.

306. See Adams, *supra*, note 299 at 579 n. 168.

and the rubrics of "gift" and "donation" are not clear on the question.[307] Those terms reflect the prohibition against paying persons who provide organs. They also imply that making tissue available for transplant is an act of charity — that doing so is morally praiseworthy but not necessarily a matter of moral obligation.[308]

Is there, in fact, a moral duty to donate tissues? Many philosophers have contemplated a general duty to do good unto others. Among them, the eighteenth-century German philosopher, Immanuel Kant, is noteworthy for his discussion of beneficence.[309] Thus, the notion of a general duty to help others has developed a respectable philosophical lineage following upon those thinkers. Indeed, theories of justice and social contract might suggest that one must be willing to give to be entitled to receive. As we shall see, however, the primary difficulty lies less in the soundness of the argument than in the practical policies apparently needed to implement a duty to donate.

Kant posits a duty to act based on the maxim that we all sometimes need the help of others:

> A . . . man finds things going well for himself but sees others (whom he could help) struggling with great hardships; and he thinks: what does it matter to me? Let everybody be as happy as Heaven wills or as he can make himself; I shall take nothing from him nor even envy him; but I have no desire to contribute anything to his well-being or to his assistance when in need . . . . But . . . it is impossible to will that such a principle should hold everywhere as a law of nature. For a will which resolved in this way would contradict itself, inasmuch as cases might often arise in which one would have need of the love and sympathy of others and in which he would deprive himself, by such a law of nature springing from his own will, of all hope of the aid he wants for himself.[310]

Three points about this argument need to be recognized. First, Kant distinguishes a duty not to harm from a duty to benefit others. The former is an undisputed, stringent moral requirement; it is the heart of law, morality and medical ethics. The extent to which morality proceeds beyond this minimum, negative duty and imposes positive duties to help others is contested. Secondly, it is unclear whether Kant intended these as noble, societal Golden Rules or as simple appeals to enlightened self-interest. Thirdly, Kant viewed any moral duty of beneficence as discretionary,[311] not absolute. A general duty of beneficence may be fulfilled in many ways, then; it does not necessarily dictate a specific moral duty to give tissue to the needy.

How might a moral duty to donate tissues be derived? Two leading strategies adopt different interpretations of Kant's argument. Proponents of the first argue, on the ethos

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307. See David A. Peters, "An Individualistic Approach to Routine Cadaver Organ Removal" (1988) 69 Health Progress 25. See also *supra*, note 239.

308. See Ramsey, *supra*, note 243 at 185-86 ("Gifts are not rights to be claimed or duties to be imposed").

309. See Immanuel Kant, *Grounding for the Metaphysics of Morals*, trans. J.W. Ellington (Indianapolis: Hackett, 1981).

310. *Ibid.* at 32.

311. *Ibid.* at 30 n. 12.

of individualism,[312] in favour of a moral duty to donate tissue effective at death. The argument is based on prudence.[313] Rational, self-interested individuals recognize a duty not to harm others because it permits them to live free of threats of harm from others. A similar[314] kind of self-interest may ground a duty to benefit others:

> [T]he same reasoning would lead individualists to adopt the *rule (requirement) of easy rescue*. Such a rule demands that individualists give up, as bystanders in an emergency, their freedom to choose whether they will aid the endangered party. The rule requires that a witness give a victim any significant assistance that involves little or no cost or risk to the witness. . . . The gain-to-risk ratio of such a rule would be highly attractive to individualists. In exchange for accepting a modest inconvenience as witnesses to an emergency, individualists gain increased assurances that they will be rescued if in peril. The promised protection allows individuals to better plan activities, which enhances freedom.[315]

Although planning for emergencies seems an awkward notion of freedom, it is plausible that self-interest would compel many to strike a social contract that includes a moral duty of beneficence. Similar logic might also support post-mortem tissue procurement policies of presumed consent or routine procurement. In short, rational, self-interested individuals might choose a societal procurement policy that maximizes their probability of receiving a transplant while alive, if they need one, at the risk of having their tissues taken posthumously.[316]

The second approach to deriving a duty to help others is based on a less individualist, more Golden-Rules view — namely, helping simply for the sake of helping, as embodied in the notion of good Samaritanism. The moral appeal is made painfully persuasive by example:

> A woman's head-dress catches fire: water is at hand: a man, instead of assisting to quench the fire, looks on, and laughs at it. A drunken man, falling with his face downwards into a puddle, is in danger of suffocation: lifting his head a little on one side would save him: another man sees this and lets him lie. A quantity of gunpowder lies scattered about a room: a man is going into it with a lighted candle: another knowing this, lets him go in without warning.[317]

If the moral duty to be a good Samaritan is readily acknowledged, the difficulty lies in the third task of practical ethics — that is, formulating a policy to implement an attractive

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312. Peters, *supra*, note 307 at 25.

313. *Ibid.* ("Rational individuals who preemiently value liberty would find it prudent to accept the duty of easy rescue and the duty to consent on the ground that personal liberty and welfare are likely to be better protected and advanced in a society that abides by these rules than in a society that does without them").

314. See Robert Lipkin, "Beyond Good Samaritans and Moral Monsters: An Individualistic Justification of the General Legal Duty to Rescue" (1983) 31 U.C.L.A. L. Rev. 252.

315. Peters, *supra*, note 307 at 26.

316. See Muyskens, *supra*, note 252 at 97.

317. J.H. Burns and H.L.A. Hart, eds, *An Introduction to the Principles of Morals and Legislation* (London: Athlone, 1970) at 293 n. u.

theoretical position. Indeed, this difficulty is often invoked to explain why the law may not follow morality in this regard.[318] Specifically, what are the practical implications for bad Samaritans in tissue procurement law?

One attempt at a solution was enacted in Singapore in 1987. Its presumed-consent law for the posthumous procurement of kidneys treats persons unwilling to give differently than those willing to give:

> For the purposes of this proposed law Muslims would be presumed to object [on religious grounds] and are thus to be classified along with objectors. . . . Such persons are put in a lower priority group for receiving kidneys.[319]

In essence, the law creates a two-tiered system of entitlement to kidney transplant resources, based on willingness to give. Is this fair?

The answer may depend on how much one is impressed by the claim that persons most prepared to give should be most eligible to receive.[320] Is the moral basis of the claim contractual self-interested individualism, charitable humanitarian benevolence or both?

Moral and practical intricacies also arise in any attempt to enforce on living potential donors a moral duty to donate. In an oft-cited case on the issue, a leukemia patient sought a court order compelling his cousin to donate bone marrow to him.[321] Legal formulations of a duty to rescue typically relieve the duty if it would involve appreciable risk.[322] But the judge did not reach that stage of the inquiry:

> The common law has consistently held to a rule which provides that one human being is under no legal compulsion to give aid or to take action to save another human being or to rescue . . . For our law to *compel* defendant to submit to an intrusion of his body would change every concept and principle upon which our society is founded. To do so would defeat the sanctity of the individual, and would impose a rule which would know no limits, and one could not imagine where the line would be drawn.[323]

The court, while apparently agreeing that the potential donor had a moral obligation to help his needy cousin,[324] refused to translate the moral duty into a legal duty. The case suggests that in concrete conflicts between the moral values of beneficence and autonomy, beneficence may not prevail.

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318. For a fuller discussion of a legal duty to rescue, see pages 89-91 below.

319. T.K.K. Iyer, "Kidneys for Transplant — 'Opting Out' Law in Singapore" (1987) 35 Forensic Sci. Int'l 131 at 135. Muslims comprise 16% of the Singapore population. *Ibid.* at 132. For the text of the law, see *The Human Organ Transplant Act 1987*, reproduced in (1990) 41:2 Int'l Dig. Health Leg. 257. See also Peters, *supra*, note 307 at 27.

320. See Peters, *supra*, note 307 at 27-28.

321. *McFall* v. *Shimp*, *infra*, note 533. See also Scott, *supra*, note 268 at 127-39.

322. See the discussion in chap. 3, pages 89-91 below.

323. *McFall* v. *Shimp*, *infra*, note 533 at 91.

324. But see Beauchamp and Childress, *supra*, note 236 at 201.

IV. Our Bodies, Our Selves

Our earlier discussion of cadaveric transplantation exposed how different views on procuring tissues from the dead reflect different views on the relationship between one's body and one's self. Those who hold that persons do not merely live in their bodies, but rather are "lived bodies," accord substantial respect to the dead body, because it is emblematic of humanity and personhood. When body and self are inextricably one, the respect owed to persons perfuses human bodies and continues after death. This view rejects regarding or treating the body as a storehouse of parts to be used for refurbishing other bodies.

By contrast, those who perceive a tenuous link between body and self view the body as necessary for the expression and facilitation of the self but of no inherent value in its own right. For them, the body possesses instrumental value; it may, therefore, be used as an instrument for benefitting other selves. This view is more accommodating of routine procurement: "Since the human identity with the body is incidental, one need not seek permission from the predeceased or the family for extracting, in a good cause, organs, blood, or tissue."[325] The following discussion explores the philosophical sources of these opposing views and applies them to notions of bodily commerce and bodily property.

The concept of persons as embodied selves is embedded in several religious traditions. A current within Protestant ethics adheres to the "very realistic view of the life of man who is altogether flesh."[326] Traditional Jewish ethics also "expresses this concern for man's embodied existence and joyfully affirms the integrity of the flesh."[327] Such views may impose strict religious and moral strictures on the posthumous invasion and use of the body.[328]

By contrast, the concept of persons as disembodied selves stems as far back as seventeenth-century secular thought:

> . . . Cartesian mentalism and dualism of mind (soul, person) and body . . . is endemic to the modern mentality and an epidemic afflicting almost all contemporary outlooks. Our culture is already prepared for technocratizing the bodily life into collections of parts in which consciousness somehow has residence for a time. . . . The contagious dualism of modern culture has already placed [man], as a spiritual overlord, too far above his physical life. To most of us a part of the body or the bodily life as a whole is already only a thing-in-the-world, not to be identified with the person.[329]

Modern scientific thought, the cornerstone of contemporary medical practice, is a result of the Enlightenment. Perhaps science and medicine could have evolved in the absence of the Cartesian dualism of mind and body. Nevertheless, it is firmly entrenched in both.

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325. May (1985), *supra*, note 245 at 39.

326. Ramsey, *supra*, note 243 at 187.

327. *Ibid.* See also May (1985), *supra*, note 245 at 39 (summarizing religious outlooks on the self and the body).

328. See further discussion in chap. 3, pages 140-42 below.

329. Ramsey, *supra*, note 243 at 193.

Indeed, the success of modern medicine is largely a result of the preoccupation with the body. As such, some thinkers even blame science for contemporary moral ills:

> At the bottom of the trouble ... is the hegemony of modern natural science, to whose view of nature even the partisans of personhood and subjectivity adhere, given that their attempt to locate human dignity in consciousness and mind presupposes that the subconscious living body, not to speak of nature in general, is utterly without dignity or meaning of its own.[330]

Modern moral theory has not been immune from the mind-body dualism that has pervaded Western thought for centuries. Some critics maintain that "the theorists of personhood, consciousness, and autonomy ... treat the essential human being as pure will and reason, as if bodily life counted for nothing, or did not even exist."[331] One school of philosophy, the Anglo-American analytic tradition, encompasses and reflects the Cartesian dualism.

A different school of philosophy, the Continental phenomenological tradition, "emphatically aims at the dissolution of the mind-body dichotomy."[332] This school rejects the objectifying, reductionist methodology of science, and takes subjective experience as the starting-point for the view that we live as embodied selves.[333] To phenomenologists, fragmenting human experience into distinct physical and mental realms is "an artifice, necessary for the scientific study of man but obstructive to philosophical thought as well as moral action."[334] Once dualism is rejected, the body is "neither an object immersed in the material world nor a consciousness positing the world."[335] Rather, it is "a structure enabling the appearance of both world and consciousness".[336]

> [T]his objectified body has a status of its own in our perceptions. Only because we drag it with us as a material object are we able to take notice of other objects as well. The same ambiguity crops up as we feel that things are not "given" to our perception but are "lived" by us. Yet as we "live" them, we make them take the shape of an objective reality because our body is geared ... to the world. Thus the human body is a primordial phenomenon for itself, but it is as well attached to a natural world in itself.[337]

These competing philosophies on the body-self relation colour our views on the good or ills of bodily property and bodily commerce.

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330. Leon R. Kass, "Thinking about the Body" (1985) 15:1 Hast. Cent. Rep. 20.

331. *Ibid.* The dualism also manifests itself in ethical criteria of "personhood." See White, *supra*, note 91 at 132.

332. Wim J. van der Steen and P.J. Thung, *Faces of Medicine* (Boston: Kluwer, 1988) at 198.

333. *Ibid.* at 150.

334. *Ibid.* at 119.

335. *Ibid.* at 155.

336. *Ibid.* See also *ibid.* at 153 ("[I]n the course of various centuries, the body came to take the shape of an artifact [cf. 14th-century anatomy, Harvey's experimental physiology, 19th-century discoveries of Röntgen photography and of spinal reflexes]. Throughout this development, man's natural ... body was gradually emptied of soul and sense, and matter was substituted for meaning. Descartes' dualism was a formal recognition of the changes suffered by the body, long before Röntgen rays and reflexes completed the process.").

337. *Ibid.* at 155.

A. Bodies, Selves and Property

What are the ethical implications of regarding the body as property? Such considerations raise a tangled skein of issues:

> My body may or may not be mine or God's, but as between you and me, it is clearly mine. And yet I wonder. What kind of *property* is my body? Is it mine or is it *me*? Can it be alienated, like my other property, like my car or even my dog? And on what basis do I claim property *rights* in my body? Have I labored to produce it? Less than did my mother, and yet it is not hers. Do I claim it on merit? Doubtful: I had it even before I could be said to be deserving. Do I hold it as a gift — whether or not there be a giver? How does one possess and use a gift? Is it mine to dispose of as I wish — especially if I do not know the answer to these questions?[338]

These questions suggest how relative and indeterminate the concept of property may be. In certain contexts and for certain reasons, it might be appropriate to regard bodies as property. In other contexts and for other reasons, it will be inappropriate. The crucial task, then, is to delineate the contexts and reasons.

What is property? Ethically, there is no simple answer, only a host of associations and distinctions accompanied by decisions about whether fulfilling certain indicia is sufficient to call something property. One legal analysis of the concept of ownership, for example, lists eleven "standard incidents" of ownership:

> Ownership comprises the right to possess, the right to use, the right to manage, the right to the income of the thing, the right to the capital, the right to security, the rights or incidents of transmissibility and absence of term, the prohibition of harmful use, liability to execution, and the incident of residuarity.[339]

If I have the rights to possess, use and manage, the right to security and the prohibition of harmful use with respect to my body, do I therefore "own" my body? These "incidents" would seem to argue yes. If so, this affirmation must itself be qualified, for it does not necessarily follow that I have other "incidents" such as the right to my body's "capital" or the right of alienation. The complete answer, then, must be: Yes, I own my body, in a sense, or for certain purposes.

Such an analysis has strengths and limits. It helps us to understand what those various senses or purposes are. In particular, it reveals that the inclination to equate property with commerce must be resisted. It is tempting, for those who want to forestall a commercial market in organs, to contend that bodies are not property. But that stance makes it difficult to explain how we can then donate organs. If this is not my kidney, what right do I have

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338. Kass, *supra*, note 330 at 23.

339. A.M. Honore, "Ownership" in A.G. Guest, ed., *Oxford Essays in Jurisprudence*, 1st ser. (Oxford: Clarendon, 1961) 107 at 113.

to give it away?[340] The issue must be refined to recognize that bodily parts may be property that carries the right of alienation, even if they cannot be property that carries a right to capital.

Such conceptual analysis also has its limits. It may expose problems without solving them. It provides a lucid answer to the question, Are bodies property? — an answer that approves the giving but not the selling of bodily parts. Yet, it does not answer implicated ethical questions, because it fails to identify the moral grounds for permitting giving but not selling. It provides little moral guidance on why we may have bodily property in one sense but not in another:

> [I]t is clear that to stare at the meaning of the word "thing" will not tell us which protected interests are conceived in terms of ownership. When the legislature or courts think that an interest should be alienable and transmissible they will reify it and say that it can be owned, that it is property. They will not say that it can be owned and is a *res* because of a prior conviction that it falls within the appropriate definition of "thing." The investigation of "things" seems to peter out in a false trail.[341]

Decisions about what "incidents" of property should attach to what objects must be made on substantive moral grounds.

Why, then, should bodies not be regarded as ordinary property? An important answer may be that notions of bodily property do violence to our concepts of personal autonomy and human dignity. Property is traditionally associated with things, not with the human body. To equate the body with a thing is to dehumanize human existence; in the extreme, it suggests the repulsive notion that human beings may be owned. This answer hinges both on a thing-person[342] dualism, and an inference that human bodily parts are reflective of our notion of self. Both are central to substantive objections to the buying and selling of human tissue.

Thus, there is difficulty in providing a general explanation of what is wrong with "alienating" one's body. Just as "property" and "ownership" have different senses, so does "alienate." Alienating a kidney by giving it for transplantation is praiseworthy; alienating a kidney by selling it is suspect. Therefore, the moral issue does not revolve around alienation *per se*, but alienation for money. So what are the substantive objections to the buying and selling of bodily tissues?

B. Bodies, Selves and Commerce

Pervasive tissue scarcity in recent years has made the buying and selling of human tissue a contentious issue in national and international communities.[343] Some analysts

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340. See Childress, *supra*, note 249 at 89, 100 ("We often think about property only in commercial terms, but even the donation of HBPs [human body parts] presupposes some conception of property").

341. Honore, *supra*, note 339 at 130.

342. See Radin, *infra*, note 460 at 1891, discussing Kant.

343. For a discussion of international concerns, see chap. 4, pages 162-63 below.

advocate sales as a means of relieving the tissue shortage.[344] Others steadfastly oppose both pre-mortem and post-mortem sales.[345] In between are those who, while concerned about potential abuses, do not object in principle to monetary exchanges for tissue. Roman Catholic moral theology may fall into the middle camp. For instance, Pope Pius XII, relying on an analogy with the sale of blood, refused to condemn payment for bodily tissue:

> [M]ust one, as is often done, refuse on principle all compensation? This question remains unanswered. It cannot be doubted that grave abuses could occur if payment is demanded. But it would be going too far to declare immoral every acceptance or every demand of payment. The case is similar to blood transfusions. It is commendable for the donor to refuse recompense: it is not necessarily a fault to accept it.[346]

What, then, are the moral merits and demerits of tissue sales? Many of these parallel the legal and policy considerations over sales that are explored below.[347] Proponents tend to base their position on the ethical value of preserving life, by couching their arguments in terms of the visible consequences of pure altruism. They contend, among other things, that: sales would significantly alleviate the current organ shortage; an increase in the supply of cadaveric tissue would reduce the need for donations from living persons and thus their exposure to the risks of surgery; an enlarged supply of tissue would improve immunological matching, thereby reducing the incidence of rejection; and any potential for major abuses or moral ills may be controlled by a limited or regulated market.[348]

Opponents base their position on both consequentialist and formalist concerns. They argue, among other things,[349] that: sales would undermine public altruism, by reducing the number of tissues that are freely given for transplantation;[350] tissue sales would undermine social justice by allowing a *laissez-faire* market to allocate tissues by the individual's ability to pay, meaning that the poor would regularly be outbid and denied equal access to life-saving opportunities.[351]

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344. See David A. Peters, "Marketing Organs for Transplantation" (1984) 13:1 Dialysis and Transplantation 40; Henry Hansmann, "The Economics and Ethics of Markets for Human Organs" (1989) 14:1 J. Health Pol. Pol'y L. 57; Lori B. Andrews, "My Body, My Property" (1986) 16:5 Hast. Cent. Rep. 28.

345. See Ramsey, *supra*, note 243 at 213.

346. *Papal Teachings: The Human Body* (Boston: St. Paul Editions, 1960), quoted in White, *supra*, note 91 at 142. See also Charles Joseph McFadden, *Medical Ethics*, 6th ed. (Philadelphia: F.A. Davis, 1967) at 297.

347. See pages 82-83 below.

348. *Ibid.* See also Theodore Silver, "The Case for a Post-Mortem Organ Draft and a Proposed Model Organ Draft Act" (1988) 68 B.U.L. Rev. 681 at 699-703. Silver, interestingly, challenges the assumption that organ sales would alleviate the prevailing shortage. *Ibid.* at 701.

349. See pages 82-83 below.

350. *Ibid.*; Titmuss, *supra*, note 244 at 225-29. If the number of altruistic tissues were likely to decrease, while the number of overall tissues increased, then the probabilities would morally pit the less tangible, less quantifiable benefits of altruism against a mixed tissue procurement regime that more effectively meets therapeutic demand.

351. Thomas H. Murray, "On the Human Body as Property: The Meaning of Embodiment, Markets, and the Meaning of Strangers" (1987) 20 U. Mich. J.L. Ref. 1055 at 1084. Sales proponents respond that any injustice of sales will be outweighed by more lives saved and that these concerns may be addressed by a regulated market. See chap. 3, section I.C(2), below.

A leading objection of opponents transcends the balancing of disadvantages and advantages. It rests on the formalist claims that human tissue sales are intrinsically immoral and dehumanizing and that they violate the respect due persons. The argument is based on the moral philosophy of Kant:

> Whatever has a price can be replaced by something else as its equivalent; on the other hand, *whatever is above all price, and therefore admits of no equivalent, has a dignity.* . . .
>
> Now morality is the condition under which alone a rational being can be an end in himself. . . . Hence morality and humanity, insofar as it is capable of morality, alone have dignity.[352]

Human dignity is the basis of the respect that is owed to all persons and that makes them priceless.

How does this intrinsic human dignity apply to our physical persons? According to one view, the apparent moral protection does not cloak the human body. For Kant, persons possess dignity and are owed respect by virtue of their rationality. If what must be morally respected is rationality, and if the capacity for rationality is located in a discrete part of the human body — say, the mind — then the rest of the body lacks special moral status. A view that reduces morality to rationality seems to end up derogating the body.[353]

Thus, the cogency of the Kantian concern seems to hinge on the now familiar competing views of the body-self relation. One's view of the strength of that relation will influence one's view of the good or ill of thinking of human bodily entities in commercial market terms. For those who regard the body as simply a physical substratum for the self, there seem few intrinsic impediments to tissue sales. There is no basic moral objection to using the body to further the ends of self. Since the body has only instrumental value, there is no reason why that instrumental value should not receive a price. For those who reject the mind-body dualism and equate the body with self, human dignity permeates the entire human body and should keep it priceless:

> The dispute between those who believe that commercialization of the human body is justified and those who think it is not seems mostly to be an argument between those who accept a dualistic view of the separation between body (material, physiological being) and mind (immaterial, rational being), and those who do not.[354]

For those sensitive to the Kantian concern, but mindful of the degree to which monetary exchanges already help supply and speed therapeutic human tissue transfers, pragmatic distinctions may offer a moral basis for tolerating some monetary tissue exchanges as not violative of human dignity. For it might be argued that some bodily by-products, substances or subparts surely do not connote the dignity of persons, but rather resemble things:

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352. Kant, *supra*, note 309 at 40-41 (emphasis added). The notion of "price" here should not be understood narrowly to include only a price determined by a market.

353. See White, *supra*, note 91 at 132-34, discussing J. Fletcher and H.T. Engelhardt.

354. White, *supra*, note 91 at 143.

> Even if selling HBPs [human body parts], such as solid organs, would be potentially dehumanizing to the society, there is debate about whether dehumanization results from the sales of all human biological materials, including surplus tissues and fluids (e.g., hair and urine) and renewable tissue (e.g., blood). . . . In addition, some proponents of a market would distinguish living vendors from cadavers and exclude situations in which a conflict of interest existed (e.g., the sale of aborted fetuses or fetal tissues). Furthermore, it would be possible to distinguish types of valuable consideration, such as direct payments and indirect incentives. For example, could the line be drawn between direct payment and coverage of a donor's medical expenses, compensation of a living donor's lost wages, and payment for the burial expenses of a deceased donor?[355]

Are such distinctions morally persuasive? While they may appeal to the balancing needs of public policy, they still sometimes offer thin ethical bases. It is not clear, for example, how an ethically meaningful line can be drawn between direct payments and indirect incentives. There might appear to be a principled difference between offering cash as an incentive to donate and reimbursing out-of-pocket expenses. But in practice the difference may vanish. Direct payment may be thought objectionable because it constitutes an undue incentive. Reimbursement for expenses, in contrast, may be thought unobjectionable because it functions to remove disincentives rather than to create incentives. Yet, social reality indicates that what counts as an incentive depends as much upon the situation of the potential recipient as it does upon the amount and spirit of the offering. The sum of $250 for participating in a drug research protocol does not have the same economic value for a salaried professional as for a poor student. To the former it does not approach adequate compensation; to the latter it might tend towards undue incentive.[356] Some analysts thus regard such distinctions as illusory or fictitious.[357]

Still, a strategy that recognizes meaningful differences between human tissues, and then defines the conditions under which monetary exchanges might occur, may prove more accommodating of diverse ethical concerns than a flat yes-or-no approach to an open sales market. Both a limited and an open sales market, however, remain subject to a basic concern: namely, do less ethically hazardous alternatives exist? Given the different ethical objections to sales, courting such objections would be ill-advised, if society could rely on other procurement policies to produce similar results without the attendant costs.[358] This concern has been persuasively argued in the required-request experiment ongoing in the United States.[359] The concern leads opponents of tissue sales to argue that, even

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355. Childress, *supra*, note 249 at 101.

356. Some might prefer the word "coercion." Others distinguish financial incentives from coercion. See H.J. McCloskey, "Coercion: Its Nature and Significance" (1980) 18 Southern J. Phil. 335 at 339. Indeed, assessing the moral status of undue or "irresistible" inducements is important, but that inquiry may be clouded by labelling them "coercive." "Coercion" seems to function as a conclusion, so that if an inducement is regarded as morally wrong, it is described as "coercive," to take advantage of the negative moral connotations that attach to the term.

357. See, *e.g.*, Murray, *supra*, note 351 at 1074. See also chap. 3, section I.C(3), below.

358. Childress, *supra*, note 249 at 100-01.

359. See the intellectual author of U.S. required request, Caplan, *infra*, note 987.

if a commercial tissue market is "ethically acceptable,"[360] it still needs to be proven "ethically preferable" to other acceptable procurement policies that might be identified on the spectrum from altruism to routine procurement.[361]

V. Fashioning Policies

Our discussion of the basic tasks of practical ethics — identifying, weighing and practically implementing human values — suggests some conclusions about fashioning policies to facilitate and speed the transfer of human therapeutic tissue.

First, the values that underlie and animate tissue procurement policies are diverse and dynamic. They range from the conspicuous goal of saving life to such cherished values as autonomy, justice and human dignity, and to the core ethical commands of doing good and doing no harm. These values and principles bespeak broad, sometimes amorphous, moral concepts. Many are considered fundamental. Few are considered absolute or pre-eminent. As a result, values will sometimes complement and sometimes compete against one another for primacy in diverse tissue procurement policies.

Secondly, the very nature of the moral concepts, competing values and philosophical disputes embedded in tissue procurement policy reminds us that, even amidst dire medical needs for our physical beings, we remain much of what we think, believe and value. The foregoing analysis has shown that our conscious and unconscious beliefs on the body-self relation constantly shape thought and conduct towards the living and dead human body. Indeed, divergent visions of the strength of that body-self relation colour our views on whether the dead suffer "harms," on what conduct we find ethically tolerable or abhorrent in medical use of recently deceased patients, on whether tissue sales intrinsically contravene human dignity, on whether bodily property concepts do violence to our moral picture of human beings, and on whether one procurement policy, more than another, is likely to beget harmful attitudes and practices.

Thirdly, despite the philosophical divides and difficulty in measuring, comparing and prioritizing tissue procurement values, practical ethics proves helpful in outlining potential ethical approaches and policy options. It may suggest, for example, that if a gift-of-life ethic is preferred and policy makers cannot solve the philosophical dispute over emotion in morality, a dispute that divides proponents of altruism and of routine procurement, then policy makers could judge whether the prevailing model of altruism has received a fair and sufficient test. This judgment would flow from an initial endorsement of altruism as a preferred public policy, a policy that may be modified or abandoned when it proves ineffective or too costly.

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360. This judgment must ultimately include an evaluation of when a tissue procurement policy becomes "sufficiently effective": satisfying 50%, 75%, 90% of demand? See Childress, *supra*, note 249 at 101. Similarly, for potential recipients on transplant waiting lists, how long is a reasonable wait?

361. *Ibid.* at 89. Some analysts prefer a system of family credits and routine taking to buying and selling. See May (1973), *supra*, note 245 at 4.

Similar practical judgments may suggest policy options on tissue sales. Beyond the debate over formal and consequentialist objections to sales, tissue sales might simply be judged to be a policy alternative that is ethically less preferable, especially if it can be shown that human tissue may be adequately supplied by less ethically costly options. If searching for a global prohibition or authorization proves unhelpful, drawing pragmatic distinctions between the least and most ethically offensive tissue sales might reveal viable, morally acceptable public options. Of course, because even pragmatic distinctions demand moral choice, policies based on them will also stir and touch those core societal values that seem so embedded in tissue procurement ethics.

CHAPTER THREE

Existing Tissue Transfer Law — Rights, Duties and Ambiguities

The law offers some answers to questions provoked by the increasing medical use, transfer and storage of human tissue and bodily substances. The following examination of relevant criminal, civil and common law legislation and constitutional principles addresses the major consent, property and sales issues identified in chapter 1. Because the law often concerns itself with the rights and duties of competing players, much of the focus centres on how the law allocates the interests of donors and their families, recipients, medical professionals and the community or state.

I. Common Law and Civil Law Perspectives

What rights and duties do the common law and the civil law provide as to the donation and transfer of human bodies, tissues and bodily substances from living and deceased donors? Answers to the question are not only important for historical purposes. They inform and sometimes govern legal relations regarding tissue storage and sales, consent to autopsies and like areas where legislation may be ambiguous or absent.

A. Bodily Integrity and Consent

Bodily integrity, the Supreme Court of Canada recently declared, ranks high on our scale of societal values and implicates basic rights.[362] Not surprisingly, the law gives practical effect to these values. Non-consensual touching may ground civil or even criminal liability.[363] Thus, the principle of informed consent[364] and the Quebec *Civil Code* principle of the inviolability of the human person[365] generally provide that health providers may invade a patient's person after securing his or her consent.[366]

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362. *E. (Mrs.)* v. *Eve*, [1986] 2 S.C.R. 388 at 406, 434.

363. A claim for civil liability would typically be laid in respect of battery. See, *e.g.*, *Malette* v. *Shulman* (1990), 67 D.L.R. (4th) 321 (Ont. C.A.). For discussion of criminal assault, see section II, below.

364. See Ellen I. Picard, *Legal Liability of Doctors and Hospitals in Canada*, 2d ed. (Toronto: Carswell, 1984) c. 3 at 41.

365. See *Civil Code of Lower Canada*, arts 19, 19.1, 984, 1053 [hereinafter *C.C.L.C.*]; *Chouinard* v. *Landry*, [1987] R.J.Q. 1954 (C.A.). See generally François Heleine, "Le dogme de l'intangibilité du corps humain et ses atteintes normalisées dans le droit des obligations du Québec contemporain" (1976) 36 R. du B. 2. For further discussion of tissue transfer provisions of the *Civil Code*, see section III, below.

366. For criminal law protection of the right to bodily integrity, see the discussion of assault in section II, below.

The principles are of ancient origin. Indeed, the law has for centuries recognized the obligation of physicians to seek the consent of their patients prior to initiating treatment.[367] First articulated as an action in trespass,[368] and later as an action in battery, the legal doctrine today requires physicians to disclose the purpose, the material risks of and options to a proposed medical procedure, so that patients may consent voluntarily, knowingly and intelligently.[369] Patient consent generally includes the right to decline treatment.[370] Yet, the consent requirement is not absolute. It does not apply in emergencies,[371] when the patient waives the right or, in rare instances, when it is unequivocally contrary to the patient's medical interests for the health professional to disclose information.[372]

Consent requirements are designed to effect personal autonomy, preserve bodily integrity, promote patient-physician understanding and, so, favourably affect medical outcomes. Conceptually, these requirements envisage the patient-physician relationship as a forum for a candid, mutual exchange of information,[373] one that thus becomes a partnership in rational decision making. It is presumed that patients will, despite their fears, comprehend the choices before them with the help of expert medical advice. They would likely be more co-operative and engaged in the treatment process, by virtue of heightened participation. The doctor is thought to benefit as well from the shared decision making,[374] because a more comprehending, participating patient is thought to increase the likelihood of effective treatment. Conceived as such, the right is at once functional and humanistic. It has both "an instrumental value in achieving subjectively defined well-being and an intrinsic value as an element of personal worth and integrity."[375]

Consent principles apply to the range of the medical and surgical procedures involved in the tissue donation and transplantation process, including the use of innovative or

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367. See *Slater* v. *Baker* (1767), 95 E.R. 860 (K.B.).

368. See *Mulloy* v. *Hop Sang*, [1935] 1 W.W.R. 714 (Alta C.A.).

369. See *Reibl* v. *Hughes*, [1980] 2 S.C.R. 880. See also Robert P. Kouri, "L'influence de la Cour suprême sur l'obligation de renseigner en droit médical québécois" (1984) 44 R. du B. 851. See generally Margaret A. Somerville, *Consent to Medical Care*, Study Paper prepared for the LRC (Ottawa: Supply and Services Canada, 1980).

370. *Couture-Jacquet* v. *Montreal Children's Hospital*, [1986] R.J.Q. 1221 (C.A.); *Malette*, *supra*, note 363. See also LRC, *Medical Treatment and Criminal Law*, Working Paper 26 (Ottawa: Supply and Services Canada, 1980).

371. *Murray* v. *McMurchy*, [1949] 2 D.L.R. 442 (B.C.S.C.).

372. See generally Paul S. Appelbaum, Charles W. Lidz and Alan Meisel, *Informed Consent: Legal Theory and Clinical Practice* (New York: Oxford University Press, 1987) c. 4 at 66.

373. See generally Note, "Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship" (1970) 79 Yale L.J. 1533. See also President's Commission, *Making Health Care Decisions: A Report on the Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship*, vol. 1 (Washington, D.C.: The Commission, 1982) at 41-50.

374. See Katz and Capron, *supra*, note 281 at 79, 87.

375. President's Commission, *Deciding to Forego Life-Sustaining Treatment: A Report on the Ethical, Medical, and Legal Issues in Treatment Decisions* (Washington, D.C.: The Commission, 1983) at 26. See also *Making Health Care Decisions*, *supra*, note 373 at 41-50.

experimental therapy.[376] If the ideals behind the model of informed medical choice do not easily translate into clinical practice,[377] the theory itself encounters difficulty with regard to minors[378] and mentally disabled persons when they lack the capacity for exercising choice.[379] In such instances, the parents of the minor or a legal guardian may have authority to consent to the medical procedure. Under the Quebec *Civil Code*, for example, a minor "capable of discernment" may donate tissue, if the risk assumed is not disproportionate to expected benefits, those having parental authority consent and a court authorizes the procedure.[380]

Parental or judicial power to authorize transplant-related medical interventions involving incompetent minors is not without its limits, however. The risks to the donor, any potential psychological benefits to the donor and the expected benefits to the recipient must be closely weighed in a justification of invasive, irreversible procedures such as the donation of a kidney by one minor sibling to another:

> The discretion is to be exercised for the benefit of that person, not for that of others. It is a discretion, too, that must at all times be exercised with great caution, a caution that must be redoubled as the seriousness of the matter increases. . . . Marginal justifications must be weighed against what is in every case a grave intrusion on the physical and mental integrity of the person.[381]

B. Bodily Property and Possessory Interests

In the transplantation and biotechnological age of the late twentieth century, should the law affirm or abandon the seventeenth-century legal maxim that there is no property in a body? Modern medical practice and the evolution of the law have called into question

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376. Compare *Halushka* v. *University of Saskatchewan* (1965), 52 W.W.R. 608 (Sask. C.A.), and *Karp* v. *Cooley*, 493 F. 2d 408 (5th Cir. 1974) (consent to implanting experimental mechanical heart). See also *Weiss* v. *Solomon*, [1989] R.J.Q. 731 (Sup. Ct). See generally Working Paper 61, *supra*, note 295.

377. See William A. Silverman, "The Myth of Informed Consent: In Daily Practice and in Clinical Trials" (1989) 15:1 J. Med. Ethics 6; Katz, *supra*, note 68 at 84.

378. See *Saskatchewan (Minister of Social Services)* v. *P. (F.)* (1990), 69 D.L.R. (4th) 134 (Prov. Ct) (parental authority not to consent to infant liver transplant), and W.F. Bowker, "Minors and Mental Incompetents: Consent to Experimentation, Gifts of Tissue and Sterilization" (1980-81) 26 McGill L.J. 951. For ethical considerations, see chap. 2, above. For analogous criminal law considerations, see section II, below.

379. See Paul S. Appelbaum and Thomas Grisso, "Assessing Patients' Capacities to Consent to Treatment" (1988) 319:25 N. Engl. J. Med. 1635. See also *Re Spring*, 405 N.E. 2d 115 (Mass. 1980) (court authorizing termination of renal dialysis treatment for mentally disabled man).

380. *C.C.L.C.*, art. 20. See *Cayouette et Mathieu*, [1987] R.J.Q. 2230 (Sup. Ct) (authorizing 5-year-old to donate bone marrow to brother suffering from leukemia under *C.C.L.C.*, art. 20). Amendments to these provisions have been proposed. See Robert P. Kouri, "Le consentement aux soins médicaux à la lumière du projet de loi 20" (1987) 18 R.D.U.S. 27, and Bill 125, *Civil Code of Quebec*, 1st Sess., 34th Leg. Que., 1990, which received Royal assent while this working paper was in preparation for publication. See S.Q. 1991, c. 64.

381. *Eve*, *supra*, note 362 at 427, 434 (limiting court power to authorize non-therapeutic sterilization of mentally incompetent adult). See also Bernard M. Dickens, Case Comment "*Eve* v. *E.*" (1987) 2 Can. Fam. L.Q. 103.

the validity of that rule. Human bodies, bodily parts, tissues and substances are increasingly given, transferred, taken and preserved for years, for a variety of therapeutic uses and purposes. Some bodily substances are sold. If we cannot own our bodies or bodily parts, what may we do with them?

Our analysis suggests that the common law recognizes limited property interests in the human body for particular purposes. Seeking to avoid abhorrent ethical and commercial connotations, the common law reiterates the no-property rule. At the same time, it recognizes an executor's or a family's rights of possession to the body of a deceased potential donor. Such limited possessory interests protect familial, moral and religious sentiment. For living donors, the law has also been loath to recognize property concepts in the body. It tends to depend on important, but sometimes limited, principles of informed consent and emotional distress damages, to govern the control, transfer or non-consensual use of extracorporeal tissue. In the face of the new biomedical and biotechnological imperative, our legal concept and definition of property seem increasingly critical. New developments challenge the traditional legal ambivalence of the no-property rule. They invite society to rethink its choices for a tissue transfer regime that continues to advance human dignity, privacy and bodily integrity in this new age.

(1) Deceased Donors

Both the common and the civil law have traditionally maintained that the human corpse is not the subject of property.[382] The sacrosanct nature of the dead human body understandably traces much of its origins to religious custom. The *Civil Code of Lower Canada* refers in burial matters to dead bodies as "sacred by their nature."[383] Similarly, the common law no-property rule is traced to the sixteenth- and seventeenth-century English case law and Sir Edward Coke's commentary that burial matters were within the domain of the Church, and the burial of cadavers is *nullis in bonis* (among the property of no one).[384] As the courts of England began to hear matters formerly within the jurisdiction of the courts of the Church, they imported Coke's statement into English jurisprudence concerning dead bodies.[385]

Despite the no-property rule, the common and civil law still recognized a number of interests that continue to enjoy legal protection today. For example, although the common law did not grant an absolute right to the control of one's body after death through one's

382. For commentary on the civil law perspective, see R. Dierkens, *Les droits sur le corps et le cadavre de l'homme* (Paris: Masson, 1966) at 157-58.

383. *C.C.L.C.*, art. 2217.

384. See Edward Coke, *The Third Part of the Institutes of the Laws of England*, 5th ed. (London: A. Crooke, 1671) at 103, relying partially on *Haynes's Case* (1614), 77 E.R. 1389 (larceny of burial wraps, not of body).

385. See Paul Matthews, "Whose Body? People as Property" (1983) 36 Current Legal Problems 193 at 197-204 and 240, discussing *Williams* v. *Williams* (1882), 20 Ch.D. 659 at 665.

will,[386] it and the civil law have long recognized one's right to a decent burial.[387] To effect the deceased's right to a decent burial, the law imposed on the deceased's executor or family a duty of burial and a corresponding right to possession of the decedent's body for burial:

> In Canada, this duty of burying a dead body falls upon the executors of the deceased's estate. In the absence of a will naming executors, the right to possession for burial goes to the surviving spouse . . . If no spouse survives, the right belongs to the next of kin.[388]

Some courts and jurisdictions refer to the right of possession as a "quasi-property" right.[389] It empowers spouses or the next of kin who are wronged by interference to sue for damages. The essence of such suits is damages for injury to the emotional or mental tranquillity of the next of kin, in the legal form of the wrongful infliction of emotional distress.[390] Thus, instances of interference with the right of possession arise in diverse cases, including the negligent handling or transporting of dead bodies,[391] the withholding of a body for payment of funeral expenses,[392] the unauthorized removal of hair from the deceased by a funeral home,[393] the withholding of a body for an unreasonable length of time to determine organ donor status[394] and the mutilation of the deceased during the course of an unauthorized autopsy.[395]

Indeed, the cases involving unauthorized autopsies in Canada and foreign jurisdictions suggest that the next of kin's right to possession for burial may include the right to receive the body generally free of mutilation. The issue sometimes arises in the context of hospital autopsies, which are distinct from the forensic autopsies ordered by a medical examiner or coroner in cases of sudden, unexpected, unnatural or suspicious deaths.[396]

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386. *Ibid.*

387. *Re Atkins*, [1989] 1 All E.R. 14 at 16; *Hunter* v. *Hunter*, [1930] 4 D.L.R. 255 (Ont. S.C.). *Lambert* v. *Dumais* (1942), B.R. 561. For U.S. jurisprudence, see cases collected in Annotation, "Validity and Effect of Testamentary Direction as to Disposition of Testator's Body," 7 A.L.R. 3d 747.

388. Lorne Elkin Rozovsky, "Death, Dead Bodies and the Law" (1970) 47:7 Can. Hosp. 52. See also *Lambert*, *supra*, note 387 and *Hunter*, *supra*, note 387.

389. See *Edmonds* v. *Armstrong Funeral Home*, [1931] 1 D.L.R. 676 (Alta S.C.) (spouse may sue for mental damages for unauthorized autopsy); *Philipps* v. *The Montreal General Hospital* (1908), 33 S.C. 483 at 489 (spouse may sue for mental damages for unauthorized autopsy). For the U.S. position, see *Prosser and Keeton on the Law of Torts*, 5th ed. (St. Paul, Minn.: West Publishing, 1984) at 63 and *Restatement of the Law, Second of Torts*, 2d, rev. & enl., vol. 4 (St. Paul, Minn.: American Law Institute Pub., 1979-) s. 868.

390. See S.M. Waddams, *The Law of Damages* (Toronto: Canada Law Book, 1983) at 452.

391. *Miner* v. *Canadian Pacific R.W. Co.* (1911), 18 W.L.R. 476 (Alta S.C.).

392. See *R.* v. *Fox* (1841), 2 Q.B. 242, and *Hunter*, *supra*, note 387.

393. *Mensinger* v. *O'Hara*, 189 Ill. App. 48 (1914).

394. *Strachan* v. *John F. Kennedy Memorial Hospital*, 538 A. 2d 346 (N.J. 1988).

395. *Edmonds*, *supra*, note 389.

396. See generally Christopher Granger, *Canadian Coroner Law* (Toronto: Carswell, 1984).

Forensic autopsies are governed by provincial statute.[397] Because a coroner's duties are quasi-judicial, the societal interest in the determination of unusual deaths and the administration of justice may authorize coroners to order forensic autopsies without the consent of the deceased's family.[398] Non-forensic or hospital autopsies generally require the consent of the deceased or his or her next of kin.[399] To the extent that hospital autopsies are within the scope of provincial gift-tissue legislation provisions authorizing next of kin consent to donate for transplant or "medical education and research," the consent and liability provisions of the legislation may also govern hospital autopsies.[400]

The common law principles suggest that any autopsy exceeding either normal autopsy procedures or the scope of consent may give rise to a claim for mental distress damages by the deceased's spouse or next of kin.[401] The issue apparently has yet to present itself in a reported Canadian decision. But other jurisdictions have invoked the right-of-possession principle recognized in Canadian law to decide claims of unnecessary retention of bodily parts after an authorized autopsy. Thus, the wrongful removal, destruction or unnecessary retention of organs from a body for which the family has authorized an autopsy has been found to inflict compensable mental shock and distress on the spouse or next of kin.[402] Even a coroner's retention of organs excised in a forensic autopsy has been the subject of liability when the scope of a legislatively authorized autopsy has been exceeded.[403] A recent case in the United States illustrates how the right of possession may also protect religious beliefs. In awarding damages against the hospital's unauthorized retention and cremation of organs, the court declared:

> Most religions in the world hold that the remains of a deceased must be treated with honor and respect. Judaism believes in the principle that body and soul are sacred because both are the handiwork of God and hence are entitled to reverence. . . .

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397. See, *e.g.*, *An Act respecting the determination of the causes and circumstances of death*, R.S.Q., c. R-0.2. See also Granger, *supra*, note 396.

398. See *Davidson* v. *Garrett* (1899), 5 C.C.C. 200 (Ont. H.C.). See also *Religieuses Hospitalières de l'Hôtel-Dieu de Montréal* v. *Brouillette* (1943), B.R. 441. For cases discussing when autopsy laws may unconstitutionally burden fundamental religious beliefs, see section IV.C, below.

399. See *Ducharme* v. *Hôpital Notre-Dame* (1933), 71 C.S. 377; *Edmonds*, *supra*, note 389 and *Philipps*, *supra*, note 389. See also *C.C.L.C.*, art. 20.

400. See Rozovsky, *supra* note 388. See also section III, below. For consent to autopsy requirements in foreign jurisdictions, see Einar Svendsen and Rolla B. Hill, "Autopsy Legislation and Practice in Various Countries" (1987) 111 Arch. Pathol. Lab. Med. 846.

401. See Susan Schmidt, "Consent for Autopsies" (1983) 250:9 JAMA 1161 at 1163. Compare *Edmonds*, *supra*, note 389, and *Hendriksen* v. *Roosevelt Hospital*, 297 F. Supp. 1142 (S.D. N.Y. 1969) (retention of internal organs exceeding scope of consent to autopsy may be actionable). For the Scottish approach, see *Hughes* v. *Robertson* (1913), Sess. Cas. 394 (Ct Sess. Scot.). See also *Hill* v. *Travelers' Insurance Co.*, 294 S.W. 1097 (Tenn. 1927) (non-consensual retention of deceased spouse's vital organs post-autopsy states cause of action).

402. See, *e.g.*, *Palmquist* v. *Standard Accident Insurance*, 3 F. Supp. 358 (D.C. Cal. 1933) (emotional distress damages for doctor's refusal to return organs removed during autopsy). See generally cases collected in James O. Pearson, "Liability for Wrongful Autopsy" 18 A.L.R. 4th 858.

403. See *Hassard* v. *Lehane*, 128 N.Y.S. 161 (1911); *Kirker* v. *Orange County*, 519 So. 2d 682 (Fla. App. 1988). Compare *Arnaud* v. *Odom*, *infra*, note 872.

> The applicable law thus requires those who deal with the body to do so with due regard to the feelings and beliefs of the next of kin. In other words the next of kin have an interest in the respectful treatment of the corpse, and in the case of those holding the views such as the plaintiff's, an interest akin to that protected by the First Amendment [Constitutional protection of religious freedom].[404]

The unauthorized autopsy cases suggest that the law protects the bodily integrity of the deceased as it relates to the emotional and religious interests of his or her spouse or next of kin.

The familial right to possession of the deceased is not absolute, however. Since the right to possession of the deceased is a function of the duty to bury, treatment of the body of a deceased in a manner inconsistent with burial may subject the possessor of the body to liability.[405] Moreover, reasonable legislation that advances the interests of the state may also supersede the right of the spouse or next of kin to possession. Forensic autopsies and their role in the criminal justice system have been discussed. The state's public health interest in embalming and, in some instances, destroying dead bodies may also override a spouse's or next of kin's right of possession.[406] Societal interest in the preservation of life may justify the procurement of organs or bodies under exigent circumstances or when no identifiable family member may reasonably be found.[407]

The non-absolute right of possession means that families of a potential donor have, through custom and law, a long-recognized right of possession to the deceased's body. In the absence of statutes modifying that right, it generally imposes a duty on hospitals and physicians to respect and accommodate the interests of the family of a deceased patient who has been identified as a candidate for organ donation. These rights and duties highlight a conspicuous ambivalence in the law. Technically, possession is a legal property interest that includes the basic rights of dominion and control. On the one hand, the traditional rule maintains that there is no property in the corpse; on the other hand, the law recognizes formal possessory or property interests in the dead.

The ambivalence springs, in part, from competing, evolving notions of property. One view of property focuses on how we relate to things. Another view emphasizes how people legally relate to other people, regarding things:

> In modern western societies, the property right is no longer regarded as absolute if, indeed, it ever was. . . .
>
> The term "property" is used in a wide variety of meanings. It may refer to a person's physical assets, to his real property, or to the totality of his wealth which consists of physical objects and various incorporeal rights which he is entitled to exercise, such as debts due

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404. *Kohn* v. *United States*, 591 F. Supp. 568 at 572-73 (1984). Compare *Disinterment of Body of Jarvis*, 58 N.W. 2d 24 at 28 (Iowa 1953) (consent to autopsy implies consent to retention of tissue shavings in accordance with customary pathology practices).

405. See Matthews, *supra*, note 385.

406. See Frank P. Grad, *Public Health Law Manual* (New York: American Public Health Association, 1970).

407. See discussion of unclaimed bodies legislation and *C.C.L.C.*, art. 22 (authorization of non-consensual organ procurement) in section III, below.

to him, rights in a trust fund, stocks, patent rights, and so on. Thus it may refer to physical objects and to rights. It may also refer to the legal relations between persons and such objects and rights . . .

> *It is, therefore, the content of the property right, namely, the several rights, privileges, powers and immunities which comprise it, that is of significance in law and not the physical thing or right itself.* The physical objects or rights may, after all, be multifarious, while the powers or rights are definite. . . . This simple generic list can be broken down further to give a list of specific powers, rights, privileges and immunities with respect to property. *Property, therefore, is not just a single right, but a bundle of rights or powers.*[408]

The distinction proves subtle and important. To define property in terms of rights and duties between people with regard to things makes the apparent ambivalence of the law more coherent. The distinction also frees society to rank and define, broadly or narrowly, particular rights, duties and powers. For example, if human tissue should generally be an object of neither commerce nor inheritance, does this mean that the law should not recognize any property interests in human bodily parts and substances? The answer depends, in part, on how property is conceived and defined, and for what purposes. Notions of bodily property may conjure up ethically abhorrent images of slavery — the ownership of human beings. The law of cadavers has shown, however, that a next of kin's right of possession does not include the right to sell. Nor does a housing tenant's right of possession normally include the right to sell the apartment. While property and commerce overlap, a right to sell may or may not be added to the bundle of property interests that the law confers.[409]

The no-property rule may suffer other limitations in the modern context. Both society and the medical use of the body have evolved significantly in the 300 years since the no-property rule was fashioned, when most bodies were buried in the consecrated grounds of a church cemetery.[410] Do the logic and utility of the rule fade centuries later, when confronted with unburied whole bodies and bodily parts, substances or tissues preserved as anatomical specimens, preserved in tissue banks for therapeutic use or transplanted into the living?

(2) Living Donors

Does the no-property rule encompass living donors? In Canada, there appears to be no case that specifically addresses the issue. In cases in the United States, the courts have tended to apply the no-property rule to tissue disputes involving living donors, although there are recent trends to the contrary. Four general areas in which property concepts have been at issue involve the non-consensual discarding of donated tissue, the control and transfer of deposited bodily substances, the use of non-consensually extracted bodily tissue or substances and the commercial value of bodily substances and tissue.

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408. A.H. Oosterhoff and W.B. Rayner, *Anger and Honsberger Law of Real Property*, vol. 1, 2d ed. (Aurora, Ont.: Canada Law Book, 1985) s. 102 at 5-6 (emphasis added).

409. See also chap. 2, section IV.B, above.

410. See text accompanying note 384, above.

(a) Non-consensual Discard Cases

Cases in the United States have arisen over the discarding of donated or deposited human tissue without the consent of the patient-depositor. In two cases, one involving lost eye tissue that was being examined for cancer and another involving the disposal without consent of reproductive matter in an infertility clinic, courts have avoided resolving patients' damage claims in terms of property. Instead, they have preferred to analyse them in terms of mental shock or distress to the patient.[411] Those cases seem to suggest that some courts in the United States have extended the no-property-in-a-corpse rule to a no-property-in-bodily-parts rule.

Commentators have critiqued the no-property-in-bodily-parts tendency for living donors.[412] Some jurisdictions significantly limit nervous shock claims.[413] It is argued that even when nervous shock claims and damages are available, they do not address instances when the return of valuable human tissue or material is sought.[414] The suggestion is that property concepts would better protect an individual's autonomy and person, in addition to clarifying legal rights and duties regarding the control of human tissue in particular circumstances. For example, when an institution destroys valuable human tissue without consent in a jurisdiction that limits mental damages, common law property principles concerning the destruction or spoilage of materials rightfully in one's possession might prove helpful in defining legal rights, duties and grounds of recovery.[415]

(b) Control and Transfer Cases

The issue of rights and duties regarding the control and transfer of human tissues has arisen most acutely in some recent cases involving human reproductive material. While there are no reported Canadian cases on this point, an American couple was recently successful in litigating the control of and right to transfer their frozen embryo from an

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411. See *Del Zio* v. *Manhattan's Columbia Presbyterian Medical Center* (14 November 1978), New York 74-3558 (S.D.) (reproductive matter), described in Andrews, *supra*, note 344 at 29; *Mokry* v. *University of Texas Health Science Center*, 529 S.W. 2d 802 (Tex. App. 1975) (eye tissue). Compare *Browning* v. *Norton-Children's Hospital*, 504 S.W. 2d 713 (Ky App. 1974) (patient's amputated leg).

412. See, *e.g.*, P.D.G. Skegg, "Human Corpses, Medical Specimens and the Law of Property" (1975) 4 Anglo-Am. L. Rev. 412 at 418 n. 39 ("The reason behind the traditional refusal of the common law courts to recognise property in a corpse does not apply to parts removed from living bodies. Property should vest initially in the person from whose body the part has been severed. However, he would often be taken to have abandoned or transferred his interest.").

413. See *McNeil* v. *Forest Lawn Memorial Services* (1976), 72 D.L.R. (3d) 556 (B.C.S.C.) (damages only for wilful breaches of duty); John G. Fleming, *The Law of Torts*, 6th ed. (Sydney: Law Book, 1983) at 30-31 and 146-47. But see *Restatement of the Law*, *supra*, note 389; *St. Elizabeth Hospital* v. *Garrard*, 730 S.W. 2d 649 (Tex. 1987) (awarding mental distress damages for parents of stillborn child disposed of contrary to parental wishes).

414. See Bernard M. Dickens, "The Control of Living Body Materials" (1977) 27 U.T.L.J. 142 at 147-49.

415. *Ibid*. See also *York* v. *Jones Institute*, 717 F. Supp. 421 (E.D. VA 1989) (applying bailment and detinue theories).

east-coast infertility clinic to a west-coast clinic.[416] In France, the wife of a deceased sperm depositor argued that she had a right to her husband's frozen sperm, which he had deposited for preservation after learning that he would undergo cancer treatments that risked making him sterile.[417] The court expressly rejected the argument that frozen semen was property, on grounds that human reproductive material was neither inheritable nor an object of commerce.[418] Nevertheless, it ruled that the sperm bank must return the frozen semen to the wife of the depositor, as a result of an understanding between the depositor and the sperm bank.[419] That decision suggests that agreements between tissue banks and depositors, as reflected in well-drafted informed consent forms, might help minimize disputes over the control of deposited tissues, in the absence of legislation or professional standards that sufficiently address the issue.

Disputes over reproductive substances are helpful in identifying concerns and values at issue in potential disputes over other human tissue and substances. For example, the growth in tissue banking may make the rights and duties in controlling other deposited, valuable human tissue a more prominent medical-legal issue.[420] Consent forms for autologous blood banking in Canada have referred to deposited blood in terms of property, as have professional protocols for the banking of reproductive[421] and genetic materials in the United States.[422]

(c) *Non-consensual Invasion Cases*

As the consent doctrine of medical malpractice law protects against the non-consensual invasion of a patient's body, so too might bodily-property principles help protect against the non-consensual use or disposition of bodily substances or tissues that have been removed from the body.[423] The idea was recently broached by the Supreme Court of Canada.

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416. *York*, *supra*, note 415 at 425-27, especially n. 5 (upholding patients right to sue on contractual and property interests bases, finding implied bailment contract within informed consent form governing frozen reproductive matter). Shortly after the court upheld the infertile couple's right to sue on the above grounds, the parties to the suit agreed to a settlement under which the couple transferred the embryo.

417. Trib. gr. inst. Créteil, 1 August 1984, *Parpalaix* v. *CÉCOS*, Gaz. Pal. 1984. 2e sem. Jur. 560. For an English discussion of the case, see Jones, *supra*, note 163. See also R.P. Jansen, "Sperm and Ova as Property" (1985) 11:3 J. Med. Ethics 123.

418. See Jones, *supra*, note 163 at 528-29.

419. See *ibid.* at 529.

420. See chap. 1, pages 22-27 above.

421. Ethics Committee of the American Fertility Society, "Ethical Considerations of the New Reproductive Technologies" (1986) 46:3 (Supp. 1) Fertil. Steril. 89 ("It is understood that the gametes and concepti are the property of the donors").

422. See autologous blood banking consent forms used by Autologous Inc., a company discussed in Gilmore, *supra*, note 183. See also ASHG, *supra*, note 167 at 782 ("Banked DNA is the property of the depositor unless otherwise stipulated").

423. See Dickens, *supra*, note 414.

The court held a physician's non-consensual taking and use of a patient's blood to be an unreasonable seizure under the *Canadian Charter of Rights and Freedoms*.[424] After taking a blood sample from an unconscious, hospitalized patient who had been injured in an automobile accident, the physician gave the sample to a police officer. The blood was analysed and later offered as evidence of drunken driving. The opinion may suggest a relationship between bodily property, patient autonomy, physical integrity and human dignity:

> As I have attempted to indicate earlier, *the use of a person's body without his consent to obtain information about him, invades an area of personal privacy essential to the maintenance of his human dignity*. . . . It was a perfectly reasonable thing for a doctor who had been entrusted with the medical care of a patient to do. However, I would emphasize that the doctor's sole justification for taking the blood sample was that it was to be used for medical purposes. He had no right to take Mr. Dyment's blood for other purposes. *I do not wish to put the matter on the basis of property considerations, although it would not be too far-fetched to do so*. Some provinces expressly vest the property of blood samples in the hospital, a matter I consider wholly irrelevant. . . . Specifically, I think the protection of the *Charter* extends to prevent a police officer, an agent of the state, from taking a substance as intimately personal as a person's blood from a person who holds it subject to a duty to respect the dignity and privacy of that person.[425]

(*d*) *Property and Personhood Cases*

The concept of property as a protectorate of fundamental values of personhood has been debated in a recent American case of international significance. In *Moore* v. *Regents of the University of California*,[426] a leukemia patient claimed that, without his knowledge or consent, his university doctors used his cells and tissue to develop and patent a commercially valuable anticancer drug. The drug is based on a cell line derived from the patient's diseased spleen which had been surgically removed for treatment. The patient argued that he is owed a rightful share of money generated by the patent, owing to the misappropriation of his bodily tissues.

Important aspects of the case were recently decided by the California Supreme Court. A lower court had upheld the patient's right to sue on the basis of a property interest:

> We have approached this issue with caution. The evolution of civilization from slavery to freedom, from regarding people as chattels to recognition of the individual dignity of each person, necessitates prudence in attributing the qualities of property to human tissue. There is, however, a dramatic difference between having property rights in one's own body and being the property of another. . .
>
> *The essence of a property interest — the ultimate right of control — therefore exists with regard to one's own human body*. . . .

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424. *R.* v. *Dyment*, [1988] 2 S.C.R. 417.

425. *Ibid.* at 431-32 (emphasis added).

426. 793 P. 2d 479 (Cal. 1990) (*en banc*), cert. denied 111 S. Ct 1388 [hereinafter *Moore* (1990)]. Weeks after the Commission had finalized its recommendations on tissue "ownership" and other issues discussed in this document, the California Justices decided *Moore* (1990) on principles consistent with Commission recommendations. See pages 188-89 below.

> *A patient must have the ultimate power to control what becomes of his or her tissues. To hold otherwise would open the door to a massive invasion of human privacy and dignity in the name of medical progress.*[427]

In reviewing the lower court decision, the California Supreme Court agreed that the patient may sue for violations of bodily integrity and human dignity, but it limited the basis for doing so to more conventional medico-legal grounds.

The majority of the court held that the patient may sue for a breach of informed-consent duties and for a breach of the duties of loyalty to the patient. The majority reasoned that if the patient's claims were proven true, those claims would show that the doctor had an undisclosed commercial interest in the patient's tissue at the time he recommended the surgical removal of the spleen, that this non-therapeutic interest might influence the doctor's recommended course of treatment and that a reasonable patient in those circumstances would generally want to be informed of potentially conflicting interests before treatment:

> Accordingly, we hold that a physician who is seeking a patient's consent for a medical procedure must, in order to satisfy his fiduciary duty and to obtain the patient's informed consent, disclose personal interests unrelated to the patient's health, whether research or economic, that may affect his medical judgement.[428]

A minority of the court agreed that the patient should be able to sue on informed-consent and fiduciary-duty grounds, but insisted that property grounds would best protect a patient's bodily integrity, privacy and dignity.

The divergent conclusions on the property claim flow, in part, from divergent views on existing law. The majority and minority views differed sharply over: (1) whether a state law that regulates the disposal of excised tissue extinguishes, or lets survive, patients' pre-excision proprietary rights to control post-excision use of the tissue; (2) whether the patented cell line and resulting drug were distinct proprietary products invented from raw materials, or the fruits of Moore's unique cellular qualities, qualifying him as a joint inventor; and (3) whether the protections of federal patent law affect a property-based claim for unauthorized use of excised tissue — especially for the six-year post-surgical, pre-patent era, when Moore's bodily substances were periodically extracted allegedly to supply the defendants' research and commercialization efforts.[429]

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427. *Moore* v. *Regents of the University of California*, 249 Cal. Rptr. 494 at 504, 506, 508 (emphasis added) (App. 2d Dist. 1988) [hereinafter *Moore* (1988)], affirmed in part, reversed in part, by *Moore* (1990), *supra*, note 426. Compare text accompanying note 424, above.

428. *Moore* (1990), *supra*, note 426 at 485. Compare American Medical Association, Council on Scientific Affairs and Council on Ethical and Judicial Affairs, "Conflicts of Interest in Medical Center/Industry Research Relationships" (1990) 263:20 JAMA 2790.

429. *Moore* (1990), *supra*, note 426 at 491-93, 501, 503. Paralleling the competing majority and minority property views, property law on the one hand recognizes principles under which one is entitled to the value added to his or her property by others; and, on the other hand, recognizes principles under which one acquires title by transforming raw materials into a new form or species of property, as in the conversion of wine from grapes. Compare *Firestone Tire* v. *Industrial Acceptance Corp.*, [1971] S.C.R. 357 (accession); *Jones* v. *De Marchant*, [1916] 10 W.W.R. 841 (C.A. Man.) (accession); *C.C.L.C.*, arts 429, 430, 433-35; Scottish Law Commission, *Corporeal Movables: Mixing Union and Creation* (Edinburgh: The Commission, 1976) (specification).

The majority and minority opinions also sharply diverged on broader policy concerns, such as the role of the courts and legislature in judging whether novel patient bodily-property claims would create liability destructive of beneficial medical research. Without absolutely ruling out such claims, the majority found "no pressing need" to recognize them, given the protection it perceived in the informed-consent and fiduciary- duty remedies. The minority rejected this view, arguing that the equities of preventing unjust enrichment and physical and moral exploitation of patients outweighed overstated liability concerns. It argued further that the commercial relations and ambiguities in the case — over whether informed consent or fiduciary duties extend to biotechnological and drug companies — meant that patients would be insufficiently protected without bodily property claims.[430]

The sharply contrasted opinions in *Moore* may help crystallize the issues for legislative or judicial deliberations in jurisdictions beyond California.[431] For the case is not an isolated incident. A United States government report has documented other disputes over the patenting of human biological materials.[432] More recently, a female patient claimed that her blood, placenta and umbilical cord were, without her knowledge or consent, transferred from a hospital to a California biotechnological company to develop an rDNA drug, Tissue Plasminogen Activator (TPA), which has been patented and is now licensed in Canada for use in dissolving blood clots after heart attacks.[433] While disputes over the development and commercial use of human tissues and biologics are noteworthy in the United States,[434] the cases may have import for other jurisdictions.

Is *Moore* relevant to Canada? Several developments and parallels in Canadian society may suggest so. The development of blood and drug products from human placenta and of vaccines from fetal tissue indicates that the therapeutic and commercial development of human biologics is part of Canadian medical history.[435] The Canadian biotechnological and drug industries are working on human biologics for commercial and non-commercial uses.[436] Biotechnology is accelerating the rate at which medical science may convert formerly useless human tissue into therapeutic substances with a commercial value. The traditional legal maxim "The law cares not for trifles" — *de minimis non curat lex* — may no longer apply to excised tissue and secreted substances long regarded as valueless and abandoned:

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430. *Moore* (1990), *supra*, note 426 at 493, 496, 500, 506, 516-17, 519-21.

431. See, *e.g.*, Ernest D. Prentice et al., "An Institutional Policy on the Right to Benefit from the Commercialization of Human Biological Material" (1990) 18:1-2 L. Med. Health Care 162.

432. See White, *supra*, note 91 at 23-27.

433. *Potts* v. *Genentech* (1 November 1988), Santa Clara Cnty 670331 (Cal. Sup. Ct).

434. See, *e.g.*, *United States* v. *Garber*, 607 F. 2d 92 (5th Cir. 1979) (taxability of "donor's" income from blood plasma sales).

435. See section III.A(1), below, and chap. 1, section I.B, above.

436. See *Canadian Biotechnology Industry Sourcebook 1988* (Ottawa: Ministry of State for Science and Technology, 1988).

> *Until recently, the physical human body, as distinguished from the mental and spiritual, was believed to have little value, other than as a source of labor. In recent history, we have seen the human body assume astonishing aspects of value.* Taking the facts of this case, for instance, we are told that John Moore's mere cells could become the foundation of a multi-billion dollar industry from which patent holders could reap fortunes. *For better or worse, we have irretrievably entered an age that requires examination of our understanding of the legal rights and relationships in the human body and the human cell.*[437]

Parallel legal developments have also emerged. Legal recognition of the patenting of life forms in the United States,[438] which increased by 300 per cent the number of patent applications for inventions involving human biologics,[439] has also proceeded in Canada, where human cell lines have received patent protection since the early 1980s.[440] Human genetic and cellular materials manipulated into therapeutic products thus appear to have been granted intellectual-property protection for exclusive commercial exploitation under Canadian law as well.

The confluence of these unprecedented legal and medical developments accentuates the potential for conflicts between the sources and the users or exploiters of human cells and tissues. Cultural and legal differences between the United States and Canada may help Canadian society avoid such disputes in transit through the biotechnological age. At the least, however, the parallel medical and legal developments challenge society to rethink its choices for a tissue-transfer legal regime consonant with this new age. *Moore*-like disputes are perhaps symptomatic of technico-legal revolutions which so jar pre-existing legal structure that society must endure a period of confusion and conflict before creating new, or recalibrating old, legal regimes.[441] In this instance, biotechnology calls into question what the moral and legal integrity of the human body will continue to mean.

Taken together, *Moore*, *Parpalaix* and *Dyment* further suggest that these biotechnological developments should proceed in a manner consistent with human rights. Will the recognition of limited property interests protect against non-consensual commercial use or development in those presumably rare, compelling circumstances in which bodily resources have been commercially exploited without the express and specific authorization of the patient? While individual rights cannot be absolute in a pluralist society, what legal tools will help maintain the sovereignty of human rights?[442] Will it help to reform patent law or to require doctors or researchers to disclose commercial or non-commercial

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437. *Moore* (1988), *supra*, note 427 at 504 (emphasis added).

438. See *infra*, note 977.

439. *Ibid.*

440. See the discussion of federal patent law, pages 123-24 below.

441. See Vincent M. Brannigan, "Biotechnology: A First Order Technico-Legal Revolution" (1988) 16 Hofstra L. Rev. 545 at 546-50.

442. The inclination or resistance to invoke property rights as a legal tool to protect human rights in this domain would seem to depend much on whether one accepts, rejects or perhaps ascribes to a personhood, labour, possessory or like theory of property in this context. See M.R. Cohen, "Property and Sovereignty" (1927) 13 Cornell L.Q. 8. See also Margaret Jane Radin, "Property and Personhood" (1982) Stan. L. Rev. 957 at 966.

potentials in research on excised human tissue?[443] Will limited bodily-property interests help? Viewed from an eighteenth-century perspective, such thoughts may seem ethically and legally abhorrent. Both law and medicine are dynamic enterprises, however. A Canadian commentator has written that "[t]he meaning of property is not constant. The actual institution, and the way people see it, and hence the meaning they give to the word, all change over time."[444] Viewed from a late twentieth-century human rights perspective, society might ponder whether a legal notion of limited property interests in human tissue may best serve to protect physical integrity, individual autonomy and the fundamental values of personhood.

To minimize disputes between the sources and commercial users of human cells and tissues, fiduciary principles may provide initial guidance. Patients seek medical care with the expectation and trust that medical interventions on their bodies will be undertaken for their benefit. Some courts have deemed this patient expectation to be a right, which imposes a corresponding duty on physicians to act with utmost good faith and loyalty.[445] The ethical and legal rights that attach to this patient-centred ethic have long been the hallmark of doctor-patient relations.[446] When an interest arises that potentially conflicts with a doctor's duty to exercise independent professional judgment on behalf of the patient, the duty of loyalty requires a disclosure of the conflict and the informed consent of the patient to continued medical treatment. Applied here, the principles require a doctor to disclose a potential commercial interest in the patient's tissues or bodily substances.[447] Full disclosure and the patient's informed consent would permit the patient to continue treatment. If the patient declines further involvement, or if it becomes reasonably clear to the doctor that his or her commercial interest compromises the exercise of independent professional judgment, the doctor would have an obligation to transfer care of the patient.

Yet, even a broad range of common law concepts — from fiduciary duties, to informed consent, to property interests — may not provide sufficient clarity or certainty on the competing interests, rights and duties of patients, doctors, researchers, hospitals or biotechnology firms. The complexity of the issues and interests indicate that they merit further multi-disciplinary study to discover how society may best balance the need to encourage creative biotechnological therapeutic human tissue development with the need to protect basic human rights.

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443. Compare Note, "Ownership of Human Tissue: Life after *Moore* v. *Regents of the University of California*" (1989) 75 Va. L. Rev. 1363 at 1391-92, and Randy W. Marusyk and Margaret S. Swain, "A Question of Property Rights in the Human Body" (1989) 21 Ottawa L. Rev. 351.

444. C.B. Macpherson, ed., *Property: Mainstream and Critical Positions* (Toronto: University of Toronto Press, 1978) at 1.

445. See Picard, *supra*, note 364 at 3 ("The doctor ... is in a fiduciary or trust relationship with his patient. This means the doctor has a duty to act with utmost good faith: he must never allow his professional duty to conflict with his personal interests; he must not mislead his patient."). See also *Rowe* v. *Grand Trunk Railway* (1866), 16 U.C.C.P. 500 at 506 (C.A.); *Kenny* v. *Lockwood*, [1932] 1 D.L.R. 507 (Ont. C.A.).

446. See Robert M. Veatch, *A Theory of Medical Ethics* (New York: Basic Books, 1981) at 22.

447. Compare Science Council Canada, *Genetics in Canadian Health Care*, Report 42 (Ottawa: Supply and Services Canada, 1991) at 75, and French National Bioethics Committee, *infra*, note 956.

C. Bodily Sales

If two parties strike a bargain for the sale and purchase of fine red hair, is the contract enforceable in the courts? Should a court reach a similar or different result if the subject-matter of the agreement is blood, cells, milk, bone marrow, organs or corpses? Does it matter that hair and teeth "have been traded for centuries" while the potential for organ and bodily part exchanges has arisen most dramatically only in the last few decades?[448]

Some answers to these questions are contained in provincial legislation or codes.[449] Principles of contract law, however, also provide insights into evolving societal thought and public policy on the sale of human tissue, organs and bodily parts or substances. Moreover, contract law principles may govern the sale of human milk, blood, sperm, cells and like substances excluded from provincial legislative or *Civil Code* prohibitions on tissue sales.[450]

Perhaps because the societal use of and value in bodily substances and parts have increased most in recent decades, there are few cases involving the sale of the body or bodily parts. Still, the existing cases and the general workings of contract law indicate that the validity of bodily sales contracts depends on two general principles: first, whether the parties to the agreement give free, uncoerced consent; and secondly, whether the agreement violates public policy or order by its illegality, immorality or clear injury to the public good.[451]

(1) Contracts, Consent and Fairness

The law has a long tradition of leaving individuals free to enter into agreements; indeed, it generally presumes in favour of enforcing agreements.[452] However, when circumstances arise in which a person has made promises under severe distress, the courts may inquire into those circumstances to see whether the parties made their promises free of coercion:

> [A] Court of Equity will enquire whether the parties really did meet on equal terms; and if it be found that the vendor was in distressed circumstances, and that advantage was taken of that distress, it will avoid the contract.[453]

The law of contracts also has long required that individuals strike their agreements within broad bounds of fairness and equality. The fairness principle is applied by asking whether an agreement was oppressive when the parties first reached their agreement, or whether it was made under duress of circumstances or undue influence. Similarly, in civil

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448. See Scott, *supra*, note 268 at 180.

449. For a discussion of provincial legislative and Quebec *Civil Code* sales prohibitions, see pages 131-36 below.

450. *Ibid.*

451. See text accompanying note 466, below.

452. Patrick S. Atiyah, *The Rise and Fall of Freedom of Contract* (Oxford: Clarendon Press, 1979) at 526.

453. S.M. Waddams, *The Law of Contracts*, 2d ed. (Toronto: Canada Law Book, 1984) at 382, citing *Wood* v. *Abrey* (1818), 3 Madd. 417 at 423. See also *Mundinger* v. *Mundinger* (1968), 3 D.L.R. (3d) 338 (Ont. C.A.), aff'd [1970] S.C.R. vi (emotional distress and marital breakdown void contract for the sale of land).

law the reasonable and present fear of *un mal sérieux* may invalidate consent and be a cause of nullity of a contract.[454] Thus, a court may find that the principle of fairness requires an agreement to be unenforceable.

There are no reported Canadian cases involving the validity of agreements to sell bodily parts. Yet so-called baby-selling cases in Canada and the United States illustrate some of the principal concerns. In some American adoption cases, for example, the courts have focused on whether biological mothers have exercised their free will in consenting to have their children adopted.[455] In one instance, in which an adoption agreement was found unenforceable, the mother's poor financial status and the payment she received as part of the adoption process persuaded the court that the biological mother had been subjected to sufficient "undue influence" or "duress" that she could not have voluntarily consented to the adoption.[456] Similar concerns motivated a court to strike down a surrogate-motherhood contract in the celebrated *Baby M* case.[457] By contrast, a Canadian court found that a biological mother "had made a free decision" to consent to her child's adoption, after receiving from the adopting parents reasonable legal and travel expenses incurred in the adoption process.[458]

Do the principles and concerns expressed in those adoption cases apply to agreements to sell human tissue, bodily parts or substances? On the one hand, the sale of human tissue does not involve the legal transfer of a human being and the necessity for safeguarding the child's best interest. In the absence of an innocent third party, it might be argued that competent adults should generally be free to consent to some bodily sales agreements, and that it is illegitimately paternalistic for society otherwise to interfere.[459]

On the other hand, the paternalism argument tends to equate economic freedom with the enhancement of personal liberty; if liberty is also seen as the power to foster and

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454. See Waddams, *supra*, note 453 at 376, 384; American Law Institute, *Restatement of the Law, Second of Contracts*, 2d. ed., vol. 2 (St. Paul, Minn.: American Law Institute Pub., 1973-) ss 173, 177; Robert W. Clark, *Inequality of Bargaining Power* (Toronto: Carswell, 1987) at 93, 207. For civilist commentary see Jean-Louis Baudouin, *Les Obligations* (Cowansville, Que.: Yvon Blais, 1983) at 122-24, discussing *C.C.L.C.*, arts 994-995.

455. See generally Jack W. Shaw, "What Constitutes Undue Influence in Obtaining a Parent's Consent to Adoption of Child" 50 A.L.R. 3d 918.

456. See *In Re G*, 389 S.W. 2d 63 at 69 (Mo. App. 1965). See also *Gray* v. *Maxwell*, 293 N.W. 2d 90 at 95 (Neb. 1980). But see *Barwin* v. *Reidy*, 307 P. 2d 175 at 185 (New Mex. 1957) ("not duress of a type which renders void contracts").

457. See *Baby M*, 537 A. 2d 1227 at 1249 (N.J. 1988).

458. *Re Female Infant* (1982), 34 B.C.L.R. 177 (S.C.) (granting application for adoption).

459. Bernard M. Dickens, "Legal and Ethical Issues in Buying and Selling Organs" (1987) 4 Transplantation/Implantation Today 15 at 20 ("The view that the freedom of choice enjoyed by the poor is protected or enhanced by denying them means to avail themselves of such an opportunity for earning is itself ethically objectionable, however, on several grounds. It denies the poor a means of income available to others, it in no way mitigates the poverty it finds an offensive cause of exploitation, and it is unjustifiably paternalistic. The poor are in no greater need of protection against exploitation than others, and can be no less trusted than others to decide for themselves to accept or decline means of earning lest their freedom of subsequent decision may be reduced.").

protect personhood, then justifying the non-saleability of tissue on grounds of fostering personhood might be seen as freedom enhancing.[460] In this sense, the legal terms "duress" and "undue influence" might describe both the medical and economic desperation which disables some persons from freely choosing or voluntarily consenting to tissue sales. When one's adolescent child is suffering from fatal leukemia, an offer of $5,000 to attract a matching bone marrow donor may seem reasonable to the parents.[461] Similarly, an offer to sell a kidney for $32,000 might seem reasonable to someone unemployed for three years in a society with hundreds on recipient waiting lists for a kidney transplant.[462] Indeed, analysts and task forces in Canada, the United States and Europe have argued that the sale of organs and bodily parts invites, and may result in, the economic exploitation of the poor.[463] In a broader sense, the dispute over whether sales aggravate or ease economic desperation reflects divergent views on redistributive justice — that is, how a tissue sales prohibition or authorization specifically affects the underlying problem of gross maldistributions of wealth in society.[464]

(2) Agreements Contrary to Public Policy or Order

Some bodily sales agreements may not be enforceable because the law regards them as void and contrary to public policy:

> It is the duty of the courts to give effect to contracts . . . since we are under a reign of law; *but there are cases in which rules of law cannot have their normal operation because the law itself recognizes some paramount consideration of public policy which overrides the interest and what otherwise would be the rights and powers of the individual*. It is, in our opinion, important not to forget that it is in this way, in derogation of the rights and powers of private persons, as they would otherwise be ascertained by principles of law, that the principle of public policy operates.[465]

The Quebec *Civil Code* recognizes a similar principle by requiring that contracts not be contrary to "good morals or public order."[466]

Whether a particular agreement is contrary to public policy or order depends on whether it offends several established legal principles or more general and evolving legal criteria. A contract to commit a crime, for example, is both void and illegal.[467] The eighteenth-century British common law crime of selling a corpse appears to have been adopted into

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460. See Margaret Jane Radin, "Market-Inalienability" (1986-87) 100 Harv. L. Rev. 1849 at 1899.

461. See Gina Kolata, "Transplant Reward Offer Raises Furor" *New York Times* (23 June 1989) A6.

462. See Mike King, "Unemployed Nurse Offers to Sell Kidney" *The [Montreal] Gazette* (17 July 1989) A3.

463. See USTF, *supra*, note 29 at 98; Titmuss, *supra*, note 244 at 219 (blood); Margaret A. Somerville, "Access to Organs for Transplantation: Overcoming 'Rejection'" (1985) 132:2 C.M.A.J. 113. But see Dickens, *supra*, note 459.

464. See Radin, *supra*, note 460 at 1911.

465. *Re Millar*, [1938] S.C.R. 1 at 4 (emphasis added).

466. *C.C.L.C.*, art. 990 ("The consideration is unlawful when it is prohibited by law, or is contrary to good morals or public order"); see also s. 1062 ("The object of an obligation must be something possible and not forbidden by law or good morals").

467. See *Byron* v. *Tremaine* (1899), 29 S.C.R. 445 (extortion agreement). See also Waddams, *supra*, note 453 at 413-14.

the Canadian *Criminal Code*;[468] if so, an agreement to sell a corpse is void and contrary to public policy as an illegality.[469] Other illegalities in modern Canadian society are often defined in statutes such as provincial laws prohibiting the sale of organs or babies.[470] Such agreements would also be generally unenforceable because they are contrary to public policy.[471]

But what of human blood, skin, bone marrow, semen, hair and like tissues or bodily substances that may not be prohibited from being sold by provincial statutes or codes?[472] It is not clear whether such bodily sales agreements are "contrary to public policy and order." That some Quebec *Civil Code* provisions are suggestive of bodily sales being *hors du commerce* while others appear to contemplate the non-gratuitous exchange of regenerative tissue suggests that the *Code* has not definitely resolved the matter.[473] Tissue sales contracts clearly do not fit within such other established areas of unenforceable agreements as "restraint of trade" or "sales of public offices."[474] They come closer to fitting within other established areas of unenforceable contracts such as "immoral bargains" or "agreements that impair family relations."

It might be argued, for example, that the sale of sperm or gametes should be contrary to public policy because it violates public morals and impairs family relations.[475] A Paris court has found a contract involving the sale of tattooed skin to be [TRANSLATION] "illicit, immoral, and against the public order."[476] Typically, though, "immoral bargains" have referred to sexually reprehensible conduct.[477] Whether the sale of semen for use in infertility treatment is immoral or sexually reprehensible conduct today is open to question. While courts in the nineteenth and early part of the twentieth century regarded artificial insemination as adultery, immoral and a threat to family relations, they now tend to regard it as medical treatment with particular legal consequences.[478] Cohabitation agreements that

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468. See pages 109-10 below, discussing *Criminal Code* s. 182.

469. See Waddams, *supra*, note 453 at 412.

470. See note 499, *infra* (babies) and section III, below (organs).

471. See Waddams, *supra*, note 453 at 421.

472. See pages 134-35, below.

473. Compare *C.C.L.C.*, arts 19, 20, 1059. For a description of the *vénalité-gratuité* debate in drafting the *Civil Code* sections, see Heleine, *supra*, note 365 at 55-63. Compare Jean-Christophe Galloux, "Réflexions sur la catégorie des choses hors du commerce: l'exemple des éléments et des produits du corps humain en droit français" (1989) 30 C. de D. 1011 and Marie-Angèle Hermitte, "Le corps hors du commerce, hors du marché" (1988) 33 Arch. Phil. Dr. 323. Recently proposed reforms to the *Civil Code* would abandon the regenerative/non-regenerative distinction, and require that the alienation of bodily parts, tissues and organs be gratuitous. See Bill 125, *supra*, note 380, art. 25.

474. See Waddams, *supra*, note 453 at 416-19.

475. See *Bonisteel* v. *Saylor* (1890), 17 O.A.R. 505 (immoral selling scheme); see also Waddams, *supra*, note 453 at 413; *Farrar* v. *MacPhee* (1971), 19 D.L.R. (3d) 720 (P.E.I.S.C.) (immoral cohabitation).

476. Trib. gr. inst. Paris, 3 June 1969, *Dlle X...* v. *Soc. Ulysse-Productions et cons.*, Gaz. Pal. 1969. 2e sem. Jur. 57.

477. Diana Brahams, "Kidneys for Sale" (1989) 139:6393 New L.J. 159. See also Baudouin, *supra*, note 454 at 189 n. 33, citing *Langelier Limitée* v. *Demers* (1928), 66 S.C. 120.

478. Compare *Orford* v. *Orford* (1921), 58 D.L.R. 251 (Ont. S.C.) and *Purpalaix* v. *CÉCOS* discussed in Jones, *supra*, note 163 at 530-31.

were once considered immoral now tend to be enforced and may even be advisable.[479] In short, legal and societal views of what is an acceptable or an immoral agreement and public policy are not static:

> Decisions on a question of this sort cannot be crystallized into categories established at some date in the past for, as an American court said, the public policy of one era may be wholly opposed to that of another. A society's view of public policy does not alter only by radical political change, but also by gradual evolution. . . . These categories reflect the values of the era. An evolving society must, however, have changing values, and the law fails in its service to society if it cannot also evolve.[480]

Absent determinative legislation or common law or civil law principles, the answer to whether some bodily sales agreements are contrary to public policy or public order may depend on the merits of the competing considerations that follow:

- **Physical integrity versus medical risks**: On the one hand, selling human tissue, bodily parts and substances may invite sellers to compromise their health and take undue physical risks; on the other hand, the physical and medical risks associated with giving some bodily parts or substances — hair, blood, sperm, sweat, milk or cell lines — arguably are so minuscule that they diminish concerns about physical exploitation or risks that may result from some authorized bodily sales.[481] In the latter instances, the legal maxim "The law cares not for trifles" — *de minimis non curat lex* — applies to such sales.
- **Medical disclosure and recipient safety**: Some argue that because sellers fear that payments will not be made for defective tissues, the lure of money discourages sellers from disclosing damaging medical information — diseases, genetics, medical history — that medical authorities need to evaluate whether the tissue should be used for transplant.[482]
- **Autonomy and privacy**: Arguably, the ethical and legal presumptions of autonomy, privacy and liberty properly include the right to exchange bodily substances or parts, when such exchanges visit no material harms on third parties.[483] Some have even argued that such rights attain a constitutional dimension.[484] On the other hand, it is argued that individual privacy and liberty do not include a right to sell bodily parts or substances.[485]

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479. Compare Walter H.E. Jaeger, *Williston on Contracts*, 3d ed. (New York: Lawyers Co-operative Pub., 1972) s. 1745 and Alberta Law Reform Institute, *Towards Reform of the Law Relating to Cohabitation outside Marriage*, Report 53 (Edmonton: The Institute, 1989) at 23-27.

480. See Waddams, *supra*, note 453 at 409-10. See also Jaeger, *supra*, note 479 at 93 ("Agreements having an immoral object are unenforceable on the ground of public policy which, in some instances, is dependent upon the attitudes prevailing at the time").

481. See *National Organ Transplant Act*, Pub. L. No. 98-507, 1984 U.S. Code Cong. & Ad. News (98 Stat.) 3975, 3982 (1984) (in formulating U.S. organ sales ban, alienation of regenerative bodily parts judged not to compromise health of donor).

482. See Titmuss, *supra*, note 244 at 151-53, 219; Jones, *supra*, note 163 at 534 n. 52; 50 Fed. Reg. 35,458 and 35,459 (1985) (data showing paid donor blood presents higher risk of transmitting hepatitis than unpaid donor blood). See also *Gilmore* v. *St. Anthony Hospital*, 598 P. 2d 1200 (Okl. 1979).

483. See John Stuart Mill, *On Liberty* (Cambridge: Cambridge University Press, 1989).

484. See *infra*, note 873.

485. See *Doe* v. *Kelley*, 307 N.W. 2d 438 (Mich. App. 1981); Radin, *supra*, note 460 at 1893.

— **Personhood and inalienable rights**: Some argue that rights accorded by society to persons include an inalienable right not to be the subject of barter or treated as a commodity.[486] These concerns are expressed in ethical prohibitions against commodifying the human body (that is, treating it as a commodity) and in maintaining the inviolability of the human body. Others respond that these concerns should be weighed against increased supplies that may result from sales.[487] Moreover, they argue that some bodily parts and substances — for example, those that are regenerative — are so distinct from personhood as to be free from any legal or ethical prohibitions on the sale of human beings.

— **Equity, universality and scarce resources**: Some argue that access to scarce human therapeutic tissues or substances should be decided neither on the basis of one's ability to pay nor on the basis of the highest bidder, because to do so compromises equity and skews more important allocative criteria such as medical need.[488] On the other hand, concerns about precious tissues going to highest bidders prove most cogent when *laissez-faire* practices prevail. In societies in which payment for tissue transfers or transplants are covered and regulated by government health insurance, highest-bidder concerns and arguments are less persuasive. The medical expenses of kidney and bone marrow donors, for example, may be covered by the transplant recipient's provincial health insurance or by separate insurance.[489] Regulations establishing customary, standard and reasonable payments would thus erode incentives for donors to shop for the highest bidder.[490]

— **Enforcement and access**: Some argue that, on balance, bodily sales agreements should not be authorized because they would pose perplexing enforcement and logistical problems.[491] On the other hand, it may be argued that bodily sales agreements for some bodily substances will generally be self-policing and may well increase the supply of precious and life-saving human sources and substances.[492]

— **Altruism and access**: Some argue that authorizing bodily sales discourages people from donating for charitable purposes and erodes a public policy of altruism, the gift-of-life ethic.[493] Other analysts respond that pure altruism has never existed, that the policy has failed to increase the supply of precious human bodily tissues and substances and that continued adherence to the system prolongs avoidable human suffering and

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486. See *Adoption of B.A.B.*, 534 A. 2d 1050 at 1052 (Pa. 1987) (human beings not merchandise); Radin, *supra*, note 460 at 1899.

487. J. Robert S. Pritchard, "A Market for Babies" (1984) 34 U.T.L.J. 341 at 352.

488. See *Baby Girl D*, 517 A. 2d 925 at 927 (Pa. 1986) ("choice not rest solely on wealth of parties" in adoption cases). See also Susan Rose-Ackerman, "Inalienability and the Theory of Property Rights" (1985) 85 Colum. L. Rev. 931 at 948.

489. See Blake and Cardella, *supra*, note 121 at 774; Buskard, *supra*, note 51.

490. See Sharpe, *supra*, note 201; Dickens, *supra*, note 459 at 21. See also French milk bank regulations, *infra*, note 934.

491. MLRC, *Report on The Human Tissue Act*, Report 66 (Winnipeg: The Commission, 1986) at 110.

492. Russell D. Roberts and Michael J. Wolkoff, "Improving the Quality and Quantity of Whole Blood Supply: Limits to Voluntary Arrangements" (1988) 13:1 J. Health Pol. Pol'y L. 167.

493. Titmuss, *supra*, note 244 at 225-29; USTF, *supra*, note 29 at 96, 98. See generally chap. 2, section I.A, above.

illness.[494] If the failings of pure altruism need not necessitate pure commercialism, modified altruism — a mixed public policy recognizing an appeal to both non-monetary and monetary personal benefits — may be in order to increase supplies.[495]

Many of these considerations, such as the impact upon safety and the enforcement of tissue sales agreements, address the practical consequences of authorizing or prohibiting tissue sales. Other considerations, such as the impact on altruism, echo the deeper ethical debate on defining emerging tissue transfer regimes for bodily substances that have not traditionally been associated with the marketplace.[496] For some analysts, allowing even limited tissue sales, or applying market rhetoric to the human body, does violence to how we think of human dignity, our bodies, our selves and concepts of personhood.[497]

(3) Payment of Reasonable Expenses

The public policy and legal considerations on bodily sales should also be guided by an understanding of the precise purposes of allowing or forbidding payments to donors. The purposes have important practical, legal and ethical consequences.

The practical consequences are plain. The transfer of human bodily tissue, parts or substances may be done: (1) gratuitously, meaning that the donor receives no payment; (2) for profit, meaning that the donor receives payment beyond expenses incurred; (3) for reasonable out-of-pocket expenses, meaning that the donor receives a nominal payment to cover associated travel, meal, lodging and like expenses; or (4) for reimbursement to the donor for expenses, lost income *and* pain and suffering. How does and should the law and public policy account for these different purposes and levels of payment?

If society deems profiting from the exchange of human bodily substances abhorrent, should it flatly prohibit all payments associated with the donation process? If yes, implementation may have undesired consequences that may prove counter-productive in practical terms. For those already undergoing medical procedures involving the removal of donated tissue, donation may simply involve an extension of planned procedures. Otherwise, the donation process requires donors to spend time and money and undertake medical risk to effect their charitable or altruistic intentions. Depending on the donor's financial situation, the lost income and travel and meal expenses may erect financial barriers that so severely tax the donor's charitable intentions that donation may become, in practice, unfeasible.

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494. Lloyd R. Cohen, "Increasing the Supply of Transplant Organs: The Virtues of a Futures Market" (1989) 58 Geo. Wash. L. Rev. 1 at 2, 33 (recommending $5,000 payment to seller/donor's estate or designee upon actual post-mortem organ procurement); Jack Kevorkian, "Marketing of Human Organs and Tissues Is Justified and Necessary" (1989) 7:6 Med. Law 557.

495. Roberts and Wolkoff, *supra*, note 492.

496. See pages 57-61, above.

497. See Radin, *supra*, note 460 at 1877-87 (market rhetoric fosters a morally inferior concept of personhood). See also pages 57-61 above.

The frequency of donation and the time and travel necessary to make the donation vary according to the tissue to be donated. Still, these considerations suggest that a policy or law that flatly forbids any payments in the donation process may itself undermine donations, because of the associated expenses, lost income, pain and suffering and the medical risks which donors often incur.

An alternative approach, as a federal working group on organ transplants has urged, is "that the donor should neither gain nor lose financially by the donation."[498] There are pros and cons to that approach. On the one hand, it arguably departs from the principle of charitable and gratuitous donations, creates a financial incentive for donation and, in the extreme, might attract and exploit the poor; moreover, it may offend and discourage the truly altruistic from donating. By recognizing the validity of some payments, it may also draw society into considerations about what are good and reasonable or bad and unreasonable payments.

On the other hand, several advantages may flow from a public policy principle that tissue donors neither gain nor lose financially from the donation process. Depending on what donation expenses are covered as "reasonable," the principle helps eliminate financial barriers to the donation process. Donors from all financial strata of society might thus have an equal opportunity to donate. Moreover, donations from reimbursed donors need not necessarily erode altruism. They might be seen as promoting it. A policy that aims at reimbursing donors for reasonable expenses and lost income still does not compensate for voluntarily assumed medical risks, pain and suffering. The uncompensated assumption of risk and pain still expresses altruism.

Finally, the approach may preserve altruism by its emphasis on payment for reasonable expenses incurred in service for society, as opposed to payment for the tissue itself. Such considerations have proven persuasive to policy makers in several jurisdictions. The distinction between reimbursement for reasonable service expenses and sales has thus been recommended for or incorporated into provincial adoption law, provincial gift tissue legislation, national ethical guidelines on research, laws prohibiting organ sales in Great Britain and the United States, and in European legislative guidelines on tissue and semen donation.[499]

A policy of reimbursing for reasonable expenses incurred in a voluntary service, in contrast to payment for the tissue itself, does have limits. In the extreme, the policy may

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498. FEDS, *supra*, note 29 at 65.

499. For the distinction in the adoption laws, see *Re Female Infant*, *supra*, note 458 (construing B.C. *Adoption Act*, R.S.B.C. 1979, c. 4, and baby-selling prohibitions); see also *Child and Family Services Act, 1984*, S.O. 1984, c. 55, s. 159; *Child Welfare Act*, R.S.O. 1980, c. 66, s. 67. In the medical research context, see MRC, *supra*, note 118 at 24-25 ("Remuneration limited to compensation for expenses actually incurred and losses reasonably assessed, including loss of wages, is ethically acceptable, provided that it does not distort freedom of choice but facilitates collaboration by indemnifying subjects for their direct and indirect expenditures. Payments for time and inconvenience, if nominal, are similarly acceptable. Excessive remuneration, or other advantages or benefits, however, are an improper inducement to participate in a research project."). In the provincial tissue law context, see pages 131-36 below. For the U.S. and European legislative context, see chap. 4, below.

create a *de facto* sales market such that the voluntary-services versus commercial-sales-of-tissue distinction pales to a fiction.[500] Still, the distinction may have other important legal consequences. It may prove significant in negligent screening suits. A negligent screening claim would likely be tested by general principles of negligence: namely, whether a tissue bank owed a transplant recipient a duty or standard of screening, had violated that standard and so caused the transmission of diseased tissue and illness or injury to the recipient.[501] If the tissue bank were regarded as being involved in the buying and selling of tissue, legal theories regarding the selling of "defective products" might also apply.[502] In this sense, some courts in the United States have debated whether tissue banks that behave more like commercial entities should be held to a stricter standard of liability.[503]

II. Criminal Law Perspectives

As an expression of fundamental societal values and as a regulator of individual conduct, criminal law also offers guidance on several tissue transfer and procurement issues.[504] It defines some of the standards, duties and responsibilities of living donors and transplant professionals in the medical treatment process. It has long played a modest but noteworthy role in the sales and provision of bodies for medicine. Moreover, although common law crimes were largely abolished in Canada in 1955,[505] the common law criminal heritage exerts a quiet, abiding influence on notions of societal harms and the mistreatment of deceased donors. Beyond its historical traditions and evolution, criminal law principles may help clarify the status of anencephalic infants and other potential donors who lie on the life-death line.

In this sense, the *Criminal Code*[506] protects rights and defines duties and criminal liability in three general areas of tissue procurement and transplantation: (1) donations

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500. See Murray, *supra*, note 351 at 1074. See also *Baby M*, *supra*, note 457 at 1247-49.

501. See *Ravenis* v. *Detroit General Hospital*, 234 N.W. 2d 411 (Mich. App. 1975) (hospital negligent in screening cadaver donor eyes for transplant). See also *Zanne*, *infra*, note 951 and *Kitchen*, *infra*, note 1028.

502. See Dickens, *supra*, note 414 at 195-97, discussing *Perlmutter* v. *Beth David Hospital*, 123 N.E. 2d 792 (N.Y. 1954) (donor payment is for service, not blood product). Several U.S. jurisdictions have codified the distinction into "blood/tissue shield" statutes that explicitly define the procurement, processing and distribution of blood and tissue as services, not the sale of products. See *McKee* v. *Cutter Laboratories*, 866 F. 2d 219 (6th Cir. 1989). The laws immunize tissue banks and hospitals from liability for "defective products" claims. This leaves banks potentially liable to negligence claims.

503. See *Gilmore*, *supra*, note 482 at 1203-07, and *Coffee* v. *Cutter Biological*, 809 F. 2d 191 (2nd Cir. 1987). See generally cases collected in Jay M. Zitter, "Liability of Blood Supplier or Donor for Injury or Death Resulting from Blood Transfusion" 24 A.L.R. 4th 508.

504. See generally Working Paper 26, *supra*, note 370 at 5-6.

505. See *Criminal Code*, R.S.C. 1985, c. C-46, ss 8, 9.

506. *Ibid.* For a discussion of the penal aspects of provincial tissue Acts, see section IV, below. See also Don Stuart, *Canadian Criminal Law*, 2d ed. (Toronto: Carswell, 1987) at 2, discussing the *Constitution Act 1867* (U.K.), 30 & 31 Vict., c. 3, s. 92(14), (15) (formerly *British North America Act, 1867*), authorizing provinces to impose fines, penalties, or imprisonment for enforcing provincial legislation as administration of justice function.

from living donors; (2) donations from deceased donors; and (3) the standard that divides those two donor pools, the legal criteria for the determination of death. How do the *Criminal Code* provisions on assault,[507] surgical and medical treatment,[508] assault causing bodily harm,[509] duties to provide necessaries of life,[510] criminal negligence[511] and homicide[512] apply to tissue donation from living donors to recipients? Do they appropriately balance the underlying values of promoting autonomy, protecting bodily integrity and preserving life? Proposals previously made by the Commission for the general reform of some of the *Code* provisions[513] prove helpful in resolving apparent conflicts or ambiguities.

For deceased donors and their families, what is the modern meaning of the eighteenth-century-based *Criminal Code* offence of indecent interference with or indignities to the dead human body?[514] Is it an indignity to sell bodily parts? How does or should this mistreatment provision apply to medical interventions on the brain-dead, mechanically maintained cadaver, which is the source of most organ transplants? Perhaps because these latter questions are unprecedented, they have received scant attention in the Canadian criminal literature. Accordingly, they are explored, as is the historic role played by criminal law in directly providing dead bodies to medical science.

In these life-death contexts, the definition of death has obvious importance. If the donor is alive, the criminal law provisions governing live donations may apply. If not, the provision relating to mistreatment of the dead body might apply. In the face of new calls that the definition of death be amended to facilitate organ procurement from a particular group of dying infants, the Commission's decade-old recommendation on criteria for the determination of brain death is revisited. Applying the pertinent medical and ethical considerations to the principles and policies on which the Commission based its initial recommendation persuades us that current invitations to amend the brain-death criteria should be declined.

A. Living Donors and Recipients

Criminal law imposes a "rule of beneficence" on some tissue transfer procedures, meaning that the benefits derived from the tissue donation and transplanting should not be disproportionate to the harms.[515] By imposing such standards on consent procedures, the donation process and surgical operations, the criminal law protects and promotes bodily integrity, life preservation and autonomy.

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507. See *infra*, note 516.

508. See text accompanying note 540, *infra*, and notes 560-562, *infra*.

509. See text accompanying notes 516-519, *infra*.

510. See text accompanying notes 528-530, *infra*.

511. See text accompanying notes 560-564, *infra*.

512. See Working Paper 26, *supra*, note 370 at 34.

513. See generally LRC, *Omissions, Negligence and Endangering*, Working Paper 46 (Ottawa: The Commission, 1985) and Report 31, *supra*, note 116.

514. See text accompanying note 675, *infra*.

515. See Working Paper 46, *supra*, note 513 at 6. See also Report 31, *supra*, note 116 at 62.

(1) Donor Rights and Responsibilities

Concerns about bodily integrity and the value of life are expressed in the responsibilities of the living donor. While the *Criminal Code* provision on assault[516] gives effect to the common law right and ethical imperative to consent to the physical invasion of one's person, other legal considerations help govern the existing model of tissue donation. For example, the recent criminal conviction of a Canadian donor for creating a common nuisance by knowingly donating HIV-infected blood underlines the concern for protecting the lives, health and safety of the public.[517] In contrast to the concern for the public health, criminal law provisions against consenting to death[518] and maiming or unlawfully causing bodily harm[519] express a concern for protecting the autonomy, health and bodily integrity of both donors and recipients, by defining the outer extremes of consent to the physical invasion of one's person. The implication of the consent-to-death prohibition is clear:

> This principle would thus preclude the altruistic donation of a liver or other organ without which the donor cannot live.[520]

The implications of the principles against maiming and unlawfully causing bodily harm have historically been more clouded in the surgical context. This principle derives from the medieval crime of mayhem, which involved permanently disabling or weakening an individual.[521] Some have argued that such principles should not be extended to organ transplants because of their significant social benefits.[522] Do such social benefits justify

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516. *Criminal Code* s. 265 provides in pertinent part, that: "A person commits an assault when (*a*) without the consent of another person, he applies force intentionally to that other person, directly or indirectly; . . ." See also Report 31, *supra*, note 116 at 61-63. For a recent medical case involving a criminal assault conviction for unauthorized rectal examinations of institutionalized mentally disabled persons, see *R.* v. *Wiens* (22 June 1985), (Ont. Prov. Ct) [unreported], discussed in Harvey Savage and Carla McKague, *Mental Health Law in Canada* (Toronto: Butterworths, 1987) at 202-203. The case further demonstrates that in protecting bodily integrity, consent requirements protect human dignity and privacy.

517. *R.* v. *Thornton* (1991), 1 O.R. (3d) 481 (C.A.). See also Tonda MacCharles, "Conviction Stuns AIDS Blood Donor" *The* [*Ottawa*] *Citizen* (16 June 1989) A1 (discussing applicability of criminal negligence and public mischief charges for such circumstances). The *Criminal Code* offence of creating a common nuisance (s. 180) provides that:

> Every one who commits a common nuisance and thereby
>
> (*a*) endangers the lives, safety or health of the public, or
>
> (*b*) causes physical injury to any person,
>
> is guilty of an indictable offense and liable to imprisonment for a term not exceeding two years.

518. *Criminal Code*, s. 14:

> No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.

519. See *Criminal Code*, s. 269; *R.* v. *Daigle* (1987), 39 C.C.C. (3d) 542 at 551-52 (Que. C.A.); *R.* v. *Innes* (1972), 7 C.C.C. (2d) 544 (B.C.C.A.). See also Report 31, *supra*, note 116 at 62.

520. J.K. Mason and R.A. McCall Smith, *Law and Medical Ethics*, 2d ed. (London: Butterworths, 1987) at 221.

521. Scott, *supra*, note 268 at 63, and *Innes*, *supra*, note 519 at 547-48.

522. See Note, "The Sale of Human Body Parts" (1973-74) 72 Mich. L. Rev. 1182 at 1240.

kidney donation from a living donor who may be related or unrelated to the recipient, when "an estimated twenty donors have died after the removal of one kidney" in transplant procedures at established institutions?[523] Some argue that a restriction against such donations is overly paternalistic, denies some donors the privilege of exercising altruism and counters the public interest in overcoming organ scarcity problems.[524] These considerations suggest that public necessity generally justifies the practice as lawful and immunizes one against the potential offence of unlawfully causing bodily harm.[525] Other concerns about potential assaults on the bodily integrity of the donor, exploiting the vulnerable and organ sales have led to recent proposals to prohibit such donations, save in limited, strictly regulated circumstances.[526] The current practice in most transplant centres is still restrictive of the use of living unrelated donors.[527]

Concerns over bodily integrity, preservation of life and harm-benefit calculi intertwine in considerations about a legal duty to donate. Are there circumstances in which the criminal law imposes a duty to donate? The *Criminal Code* requires spouses or parents to provide "necessaries of life" to their spouse or child.[528] The unexcused failure to provide such necessaries as routine tissue replacement procedures, insulin injections or blood transfusions may thus constitute a criminal offence.[529] The Commission has extended these principles

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523. Thomas E. Starzl, "Will Live Organ Donations No Longer Be Justified?" (1985) 15:2 Hast. Cent. Rep. 5.

524. See Martyn Evans, "Organ Donations Should Not Be Restricted to Relatives" (1989) 15:1 J. Med. Ethics 17.

525. See Mason and McCall Smith, *supra*, note 520 at 221. See also *Criminal Code*, s. 45, in text accompanying note 540, *infra*; Report 31, *supra*, note 116.

526. See *Human Organ Transplants Act 1989* (U.K.), 1989, c. 31, discussed in chap. 4, below.

527. See Levy et al., "Kidney Transplantation from Unrelated Living Donors" (1986) 314:14 N. Engl. J. Med. 914 at 915; Evans, *supra*, note 524.

528. *Criminal Code*, s. 215, provides, in pertinent part, as follows (emphasis added):

> (1) *Every one is under a legal duty*
>
> (*a*) *as a parent*, foster parent, guardian or head of a family, to provide necessaries of life for a child under the age of sixteen years;
>
> (*b*) *as a married person*, to provide necessaries of life to his spouse; and
>
> (*c*) *to provide necessaries of life to a person under his charge if that person*
>
> (i) is unable, by reason of detention, age, illness, insanity or other cause, to withdraw himself from that charge, and
>
> (ii) is unable to provide himself with necessaries of life.
>
> (2) *Every one commits an offence who, being under a legal duty* within the meaning of subsection (1), *fails without lawful excuse*, the proof of which lies on him, *to perform that duty*, if
>
> (*a*) with respect to a duty imposed by paragraph (1)(*a*) or (*b*),
>
> (i) the person to whom the duty is owed is in destitute or necessitous circumstances, or
>
> (ii) *the failure to perform the duty endangers the life of the person to whom the duty is owed, or causes or is likely to cause the health of that person to be endangered permanently*; or
>
> (*b*) with respect to a duty imposed by paragraph (1) (*c*), the failure to perform the duty *endangers the life of* the person to whom the duty is owed or causes or is likely to cause the health of that person to be injured permanently.
>
> (3) Every one who commits an offence under subsection (2) is guilty of
>
> (*a*) an indictable offence and is liable to imprisonment for a term not exceeding two years; or
>
> (*b*) an offence punishable on summary conviction.

529. Compare *R.* v. *Tutton*, [1989] 1 S.C.R. 1392 (intentional parental withholding of insulin injections from 5-year-old diabetic, on religious grounds subjects parents to criminal negligence resulting in death for failing to provide necessaries of life without lawful excuse) and *R.* v. *Cyrenne* (1981), 62 C.C.C. (2d) 238 (Ont. Dist. Ct) (finding parents not guilty of criminal negligence, since not proved beyond reasonable doubt that lack of blood transfusion caused death). See also *R.* v. *Lewis*, *infra*, note 909.

in a proposal that individuals be obliged to take "reasonable steps to assist" a person "perceived to be" in immediate danger of serious harm or death.[530] Such a duty has been imposed by penal codes in Belgium, France, Greece and Vermont; it addresses such classic situations as when an individual who is clearly in the process of drowning receives no assistance from companions who might help without jeopardizing their own well-being.[531] There is no duty where the rescue involves a risk of serious harm or where the would-be rescuer has other valid reasons.[532]

Applying these principles to the tissue donation process would seem to indicate that organ donation is seldom, if ever, legally required. There are no reported Canadian cases on a duty to donate *per se*. Five North American cases involving the donation of bone marrow, in the non-criminal law context, illustrate the complexity of the problem. In one, a man suffering from aplastic anemia sought a court order compelling his first cousin, who was the only identified suitable donor, to donate bone marrow.[533] The anemic man was unlikely to survive without the transplant. Despite the exigencies of the circumstances, the court denied the order on the grounds that the forceable extraction of living bodily tissue would violate the autonomy and physical integrity of the cousin. The man died shortly thereafter. While this case appeared to be decided on the basis of autonomy, the risks associated with bone marrow transplantation[534] might constitute a risk of serious harm or otherwise constitute a lawful excuse sufficient to relieve one of any duty to donate. For tissue donation involving less bodily invasion and fewer medical risks to the donor, concerns about a risk of serious harm seem less compelling.

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530. See Report 31, *supra*, note 116 at 67, cl. 10(2) ("(a) General Rule. Everyone commits a crime who, perceiving another person in immediate danger of death or serious harm, does not take reasonable steps to assist him. (b) Exception. Cl. 10(2)(*a*) does not apply where the person cannot take reasonable steps to assist without risk of death or serious harm to himself or another person or where he has some other valid reason for not doing so."). See also Working Paper 46, *supra*, note 513 at 17-20.

531. *Ibid.* See also Clare Elaine Radcliffe, "A Duty to Rescue: The Good, the Bad and the Indifferent — The Bystander's Dilemma" (1986) 13 Pepperdine L. Rev. 387. Thomas C. Grey, *The Legal Enforcement of Morality* (New York: Alfred A. Knopf, 1983) 157-97.

532. Report 31, *supra*, note 116 at 67.

533. *McFall* v. *Shimp*, 10 Pa. D. & C. 3d 90 (Allegheny Cnty Ct 1978); Case Comment, "Coerced Donation of Body Tissues: Can We Live with *McFall* v. *Shimp*" (1979) 40 Ohio St. L.J. 409; Alan Meisel and Loren H. Roth, "Must a Man Be His Cousin's Keeper?" (1978) 8:5 Hast. Cent. Rep. 5. See chap. 2, section III, above.

534. The risks associated with bone marrow transplantation have been recently summarized:

> The procedure requires hospitalization; it is performed under spinal or general anesthesia with little associated morbidity other than moderate to significant pain at the aspiration sites that persists for several days. Life-threatening complications occurred in only 9 of 3,290 reported procedures, yielding a frequency of .027 percent. These complications included nonfatal cardiac arrest, pulmonary embolism, aspiration pneumonitis, ventricular tachycardia, and cerebral infarction. The death of a donor was reported due to cardiac arrest during induction of general anesthesia. Other adverse consequences of marrow donation included bleeding, which required transfusion, one case of a broken aspiration needle where surgical removal was necessary, and a few transient episodes of hypotension, atrial arrhythmia, and laryngospasm.

U.S. Department of Health and Human Services, Public Health Service, National Center for Health Services Research and Health Care Technology Assessment, *Reassessment of Autologous Bone Marrow Transplantation* (Washington, D.C.: U.S. Government Printing Office, 1988) at 2.

Four other cases raise the issue of what a duty to take reasonable steps may encompass, short of donation. A court in the United States recently denied a petition to order three-year-old twins to submit to tests for possible bone marrow donation to a half sibling.[535] The court was asked to decide the issue when an estranged couple disputed whether the twins, who were in the custody of the mother, should submit to blood tests that would indicate their compatibility for bone marrow donation to their dying thirteen-year-old half brother whom they had never met. In an earlier case, a cancer patient sought to compel a transplant centre to disclose information, and to take further steps to recruit Mrs. X, a potential bone marrow donor with apparently compatible bone marrow.[536] The court refused the request. It found the tissue type information contained in the centre's computer to be a confidential medical record to which the cancer patient had no special right of access.[537] In other disclosure cases, involving leukemia patients' access to confidential records, courts have both denied and granted access. A Quebec court granted a child's petition to access sealed adoption records for the narrow purpose of determining whether the patient's biological parents might be potential bone marrow transplant donors.[538] An American court denied such access.[539]

The results in most of these cases may seem harsh. Laws in the jurisdictions in which the courts denied access generally do not recognize a duty to rescue. If nothing else, the cases help illustrate that, beyond concerns for respecting the bodily integrity of would-be donors, competing needs for privacy and confidentiality also inform considerations on any duty to donate. Jurisdictions seeking to impose a reasonable duty to rescue while respecting confidentiality might, as the Quebec court held, require efforts to contact potential donors on the understanding that identities not be disclosed.

(2) Reasonable Harms and Benefits

The *Criminal Code* generally protects from criminal responsibility doctors who undertake organ transplants involving reasonable patient benefit.

> Every one is protected from criminal responsibility for performing a surgical operation on any person *for the benefit of that person if*
>
> (*a*) the operation is performed with reasonable care and skill; and
>
> (*b*) *it is reasonable to* perform the operation, having regard to the state of health of the person at the time the operation is performed and to all the circumstances of the case.[540]

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535. *Curran* v. *Bosze*, 566 N.E. 2d 1319 (Ill. 1990).

536. *Head* v. *Colloton*, 331 N.W. 2d 870 (Iowa 1983); "Mrs. X and the Bone Marrow Transplant" (1983) 13:1 Hast. Cent. Rep. 17.

537. *Head* v. *Colloton*, *supra*, note 536.

538. *Droit de la famille-140*, [1984] R.J.Q. 2049 (T.J.).

539. *Application of George*, 630 S.W. 2d 614 (Mo. App. 1982).

540. *Criminal Code*, s. 45 (emphasis added).

How is the provision that surgical transplantation must benefit the patient to be reconciled with the reality that blood, bone marrow or kidney donations do not physically benefit the donor? First, by applying to surgical operations, the provision appears not to extend to blood or like donations that generally are considered medical procedures. Secondly, while the provision may appear to exclude tissue and organ transplants between family members, a number of approaches have been proposed to resolve the tension.

One approach involves construing "patient benefit" broadly, to include the psychological benefits presumed to accrue to the donor in organ transplantations and donations involving family members.[541] Yet, the psychological-benefits theory may be limited by circumstances in which presumed psychological benefits appear reduced, where, for example, donations are from unrelated donors. Moreover, some commentators question the validity of the psychological-benefits theory.[542] An alternative approach stresses that the requirement of donor benefit is presumed when consent is present.[543] This approach stems from a view that the *Criminal Code*'s fundamental premise is the protection of the person, and that it is reasonable to presume that persons act self-protectively to benefit themselves, as evidenced by consent.[544] The Law Reform Commission has adopted this view,[545] meaning that the *Criminal Code* provisions defining intentional crimes against bodily integrity[546] should not apply to tissue and organ donation undertaken with properly obtained informed consent and involving risks not disproportionate to expected benefits. Since the *Code* seems not to contemplate these medical procedures undertaken for another's benefit, appropriate reforms would seem advisable.[547] The more a procedure tends towards non-therapeutic benefit to the donor, the more stringent would seem the physician's duty of disclosure to promote consent.[548]

Neither the psychological-benefits nor consent and risk-benefits approach easily resolve the intractable complexities of organ donations from minors and mentally disabled individuals.[549] A mature minor who has the capacity[550] to understand and appreciate the risks, benefits and consequences of donating an organ to a sibling would seem to parallel

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541. See cases discussed in chap. 2, section II.B, above. See also Working Paper 26, *supra*, note 370 at 57.

542. See, *e.g.*, Margaret A. Somerville, "Medical Interventions and the Criminal Law: Lawful or Excusable Wounding?" (1980-81) 26 McGill L.J. 82 at 88 n. 16.

543. See *ibid.* at 92. See also Bernard Starkman, "A Defence to Criminal Responsibility for Performing Surgical Operations: Section 45 of the *Criminal Code*" (1980-81) 26 McGill L.J. 1048.

544. Working Paper 26, *supra*, note 370 at 58-59.

545. See Report 31, *supra*, note 116 at 63 and Working Paper 61, *supra*, note 295. See also MRC, *supra*, note 118 at 12, 21.

546. See section II.A(1), above.

547. See Working Paper 61, *supra*, note 295 at 35-36; Report 31, *supra*, note 116 at 63.

548. See *Halushka*, *supra*, note 376.

549. See generally Bernard Starkman, "*Inter Vivos* Transplantation: The Child and Dependent Adult as Donors" (1985) 17:6 (Supp. 4) Transplant. Proc. 40.

550. For a discussion of minors' competence to decide, see Margaret A. Somerville, "Refusal of Medical Treatment in 'Captive' Circumstances" (1985) 63 Can. Bar Rev. 59.

an adult in similar circumstances. The deep emotional consequences of donation or non-donation in such circumstances make consent for even the mature[551] a delicate, trying process.

For potential donors judged incompetent to consent, and thus unable to act self-protectively, the net "benefits" of the donation may justify transplants on grounds of necessity in exceptional circumstances.[552] The ethical principles of doing no harm and of beneficence[553] indicate that donations that pose no serious risks and that offer a likelihood of psychological benefits to the donor and life-saving benefits to the recipient may be justifiable. The beneficence requirement that the risk of harm not be disproportionate to expected benefits is most likely ensured by a restriction of such transfers to members of the same family. Thus, a minor sibling's donation of bone marrow to his or her brother may be seen as consistent with ethics, public policy and law.[554] However, as the invasiveness, irreversibility and risks of the transplant procedure increase — as in the case of a kidney transplant — so do concerns for the bodily integrity of all donors. To ensure that incompetent donors are protected from potential harms and that their particular vulnerability is not exploited, donations might best be considered only after other reasonable medical alternatives have been exhausted, and only if the guardian's consent has been obtained. To accord full respect to potential donors' wishes, their consent should be sought and their refusal respected. Such considerations have moved foreign analysts, such as the Australian Law Reform Commission[555] and the Council of Europe[556], to restrict donations from incompetent persons to those that can be made under similarly circumscribed conditions. Such concerns have more recently prompted the Uniform Law Conference of Canada to recommend a requirement of an "independent assessment" for

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551. See John E. Thomas, "Am I My Brother's Keeper?" (Oct. 1987) Can. Doctor GP8. See generally George Thomson, "Minors and Medical Consent" (1981) 2:4 Health L. Can.; Bowker, *supra*, note 378 at 969.

552. Report 31, *supra*, note 116 at 63; Working Paper 26, *supra*, note 370 at 59.

553. See *supra*, note 283 and section II.B, below.

554. See, *e.g.*, *Cayouette et Mathieu*, *supra*, note 380. Though no criminal law issue was raised in this case, it suggests that transplants not physically benefitting the donor may be consistent both with public policy and criminal law and ethical principles of necessity and beneficence. See Working Paper 26, *supra*, note 370 at 57.

555. See Australian Law Reform Commission, *infra*, note 1010 at 50-51 (recommending (1) that donation of regenerative tissue from minors be lawful, if the minor is of sound mind and consents to donation, a parent consents, and independent medical advice is provided; (2) that donation of non-regenerative tissue be generally prohibited, subject to exception when the following conditions are met: the donor and recipient are members of the same family, independent medical advice is provided on the nature and effect of the donation and transplantation, written parental consent, the donor has sufficient mental capacity and agrees to donation, and an independent committee unanimously agrees to the donation; and (3) that it be unlawful to take tissue from mentally disabled persons).

556. See Final Text, *infra*, note 965 at 276 (recommending a general rule against procurement from the "legally-incapacitated, subject to (1) an exception for regenerative tissue, when justified on therapeutic grounds for the recipient, the legal representative consents, and the donor consents, if the donor has the capacity to do so (s. 10); and an exception for (2) the donation of a single kidney, when neither dialysis nor a cadaveric organ is, respectively, "feasible" or "available," the donor and recipient are "genetically closely related," the legal representative and appropriate authorities consent, and the donor consents, if the donor has the capacity to do so (ss 8, 10). The recommendation generally precludes procurement that "presents a significant and foreseeable risk to the life, health or functioning of the donor." (s. 13)).

all donors of non-regenerative tissue, as well as for all tissue donors under sixteen years of age.[557] The Law Reform Commission of Canada's recommendation that decisions for such interventions proceed on a case-by-case basis would seem consistent with the Uniform Law Conference approach.[558] Even when the donation of a kidney by an incompetent minor seems ethically justified by beneficence and is immune from criminal sanction on grounds of necessity, recent concerns expressed by the Supreme Court of Canada still raise questions as to whether and when invasive, irreversible medical interventions performed on one person for the benefit of another person are legally justified.[559]

(3) Reasonable Medical Skills

Finally, the criminal law protects the bodily integrity of transplant donors and recipients, by requiring medical professionals to perform transplants and related medical procedures with reasonable knowledge, skill and care;[560] surgical-medical procedures must not be done with wanton or reckless disregard for health and safety.[561] Otherwise, performance of the procedures theoretically risks subjecting a medical practitioner to criminal negligence charges for causing bodily harm or death.

In practical terms, medical malpractice seldom subjects health care professionals to criminal liability.[562] Most claims of negligence arise in civil disputes between an injured patient and a hospital or physician.[563] In rare instances when medical mistreatment invokes potential criminal negligence, the conduct is judged by a standard that differs from that of civil lawsuits. Generally, criminal negligence requires "a marked departure"[564] from

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557. See text accompanying note 834, *infra*.

558. See Working Paper 26, *supra*, note 370 at 59. See also 1989 Uniform Act, ss 6, 7, discussed, *infra*, notes 833ff. (providing that (1) those under 16 may donate only if the results of an independent assessment indicate that the transplant should be carried out (s. 6(4)); (2) the tissue to be donated is regenerative (s. 6(1)); and (3) the minor understands the nature and consequences of the donation — a rule that is excepted by bone marrow that may be donated on behalf of the minor to the minor's biological sibling, by a guardian (s.6)).

559. See *Eve*, discussed in text accompanying note 362, *supra*.

560. *Criminal Code*, s. 266:

> Every one who undertakes to administer surgical or medical treatment to another person or to do any other lawful act that may endanger the life of another person is, except in cases of necessity, under a legal duty to have and to use reasonable knowledge, skill and care in so doing.

See also s. 45, in text accompanying note 540, *supra*.

561. *Ibid.*, ss 219, 220.

562. Working Paper 26, *supra*, note 370 at 1, 48. See also Ellen I. Picard, *Legal Liability of Doctors and Hospitals in Canada*, 1st ed. (Toronto: Carswell, 1978) at 298, 300. Compare *Wiens*, *supra*, note 516 and *R.* v. *Sullivan*, [1991] 1 S.C.R. 489 (midwives' aquittal of criminal negligence).

563. See generally Picard, *supra*, note 364.

564. Report 31, *supra*, note 116 at 25. The Supreme Court of Canada remains divided over whether an objective (reasonable person) standard or more subjective standard should govern criminal negligence. See *R.* v. *Waite*, [1989] 1 S.C.R. 1436. See also *Tutton*, *supra*, note 529. See generally Stuart, *supra*, note 506 at 183-98.

the ordinary standard of reasonable care. The standard theoretically applies to grave deviations from acceptable medical practices in diagnosing brain death,[565] or to other aspects of the transplant process.

B. Living or Deceased Donors — Anencephalic Newborns

In 1981, the Law Reform Commission of Canada proposed an "irreversible cessation of all . . . brain functions" standard for the determination of death in matters of federal jurisdiction, including the *Criminal Code*.[566] Developments in the last few years have led to calls to amend the whole-brain-death standard or to exempt from that standard a pool of patients who are born "incompatible with life": namely, anencephalic newborns. The proposal implicates criminal law principles and policy in two general respects. First, as with any potential organ donor, if the anencephalic newborn is not dead, the criminal law provision concerning medical treatment duties, failure to provide necessaries of life, criminal negligence, acceleration of death, homicide and like criminal law provisions governing live organ donors and recipients apply.[567] If live-born anencephalic infants do not meet the criteria for death,[568] this provokes a policy question in criminal law. Should the definition of death be modified for these infants who are born without most of their upper brain and who usually die within seventy-two hours after birth? Or should they be exempted from the definition so that their organs may be transplanted into those who might live? This question arises in part from the medical demand for the organs of newborns and in part from the poor medical status of the newborn anencephalic infant.

Anencephaly, which literally means "without brain,"[569] refers to a birth defect characterized by the "absence of a major portion of the brain, skull, and scalp."[570] This

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565. See *People* v. *Eulo*, 472 N.E. 2d. 286 at 297 (N.Y. 1984) ("If, however, the pronouncements of death were premature due to the gross negligence or the intentional wrongdoing of doctors, as determined by a grave deviation from accepted medical practices or disregard for the legally cognizable criteria for determining death, the intervening medical procedure would . . . become the legal cause of death"). Compare *R.* v. *Kitching* (1976), 32 C.C.C. (2d) 159 (Man. C.A.) (adopting brain-death definition of death, holding that organ procurement from brain-dead patient, who had been criminally assaulted, did not cause death).

566. Report 15, *supra*, note 1 at 25. ("For all purposes within the jurisdiction of the Parliament of Canada, (1) a person is dead when an irreversible cessation of all that person's brain functions has occurred. (2) The irreversible cessation of brain functions can be determined by the prolonged absence of spontaneous circulatory and respiratory functions. (3) When the determination of the prolonged absence of spontaneous circulatory and respiratory functions is made impossible by the use of artificial means of support, the irreversible cessation of brain functions can be determined by any means recognized by the ordinary standards of current medical practice."). For a discussion of its proposed application to the *Criminal Code*, see Report 15, *ibid.* at 23. See also *Kitching*, *supra*, note 565.

567. For a discussion of *Criminal Code* provisions affecting living organ donors and recipients, see text accompanying note 516, *supra*.

568. Such infants generally receive death certificates, suggesting that they are considered born "alive."

569. *Dorland's Illustrated Medical Dictionary*, 27th ed. (Philadelphia: Saunders, 1988) at 78.

570. The Medical Task Force on Anencephaly, "The Infant with Anencephaly" (1990) 322:10 N. Engl. J. Med. 669 [hereinafter MTFA].

condition, of still unknown causes,[571] afflicts a reported one in 3,226 newborn infants; 40 to 60 per cent of anencephalic infants are born alive.[572] Tragically, even those born alive survive for only a few hours or days, although in rare instances some live for weeks or months.[573] Some fifty newborns appear to die from anencephaly and like anomalies annually in Canada;[574] the number ranges from 300 to 600 annually in the United States.[575] More frequent prenatal screening may reduce the incidence of anencephalic births.[576] The estimated 500 to 600 newborn livers and 1,200 hearts needed annually in the United States[577] may suggest a corresponding need for fifty to sixty newborn livers and 120 newborn hearts for Canada.[578]

The poor medical status of the infant, parental desires to make some good of the circumstances and the need for organs have led to proposals and initiatives to facilitate organ procurement from live-born anencephalic infants. Some of the initiatives appear to have been medically successful:

> Baby Gabrielle, born in Canada and subsequently transferred to the Loma Linda University Medical Center in California, was anencephalic. When her parents learned of their daughter's condition and of the devastating ramifications of anencephaly, . . . they faced the inexorable reality that their daughter would be born into a process of imminent dying. . . .
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> In the hope that their infant daughter "would touch others and contribute to life in some way," Baby Gabrielle's parents arranged for their daughter's organs to be donated to infants who were in dire need of healthy organs for transplantation. One such infant was Baby Paul Holc, who was afflicted with hypoplastic left-heart syndrome. Baby Paul received Gabrielle's heart; one month after the successful transplant operation, he was discharged from Loma Linda with a second chance for a healthy, productive life.[579]

Other medical initiatives have proven less fruitful.[580]

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571. See Jack A. Pritchard, Paul C. MacDonald and Norman F. Gant, *Williams Obstetrics*, 17th ed. (Norwalk, Conn.: Appleton-Century-Crofts, 1985) at 802.

572. Jeffrey R. Botkin, "Anencephalic Infants as Organ Donors" (1988) 82:2 Pediatrics 250 at 251.

573. See Statistics Canada, *Mortality, Summary List of Causes, Vital Statistics, Volume III* (Ottawa: Statistics Canada, 1984-1988) No. 84-206, for the years 1981-86 (reporting that a few anencephalic newborns lived 1-10 months after birth).

574. *Ibid.* Deaths from "anencephaly and similar anomalies" (int'l listing No. 740) have been reported as follows for the respective years: 1986-52; 1985-66; 1984-52; 1983-78; 1982-76; 1981-87.

575. Botkin , *supra*, note 572 at 251. See also D. Alan Shewmon et al., "The Use of Anencephalic Infants as Organ Sources — A Critique" (1989) 261:12 JAMA 1773 at 1774.

576. Botkin, *supra*, note 572 at 255.

577. *Ibid.*

578. This assumes a Canadian need equal to 10% of the U.S. need.

579. Andrea K. Scott, "Death unto Life: Anencephalic Infants as Organ Donors" (1988) 74 Va. L. Rev. 1527 at 1528. See also T.C. Frewen et al., "Anencephalic Infants and Organ Donation: The Children's Hospital of Western Ontario Experience" (1990) 22:3 Transplant. Proc. 1033; George J. Annas, "From Canada with Love: Anencephalic Newborns as Organ Donors?" (1987) 17:6 Hast. Cent. Rep. 36.

580. See Joyce L. Peabody, Janet R. Emery and Stephen Ashwal, "Experience with Anencephalic Infants as Prospective Organ Donors" (1989) 321:6 N. Engl. J. Med. 344 (Loma Linda University finding that it is usually not feasible, with the restrictions of current law, to procure solid organs for transplant). See also "Anencephalic Organ Donor Program Suspended: Loma Linda Report Expected to Detail Findings" (1988) 260:12 JAMA 1671.

Practically, the dilemma presents at least four options for attempting tissue and organ procurement from anencephalic infants. Each raises varying criminal law and ethical concerns:

(1) Customary Care and Comfort: Provide customary care and comfort until the infants expire, which would reduce the likelihood of procuring viable organs, but permit the donation of tissue.[581]

(2) Brain Dead: Consider live-born anencephalic infants as brain dead,[582] born dead,[583] "brain-absent"[584] or stillborn,[585] to exempt them from the traditional heart-lung or the newer whole-brain-death standard, and thus permit a greater range of medical interventions likely to increase the number of viable organs procured for transplantation.

(3) Medical Protocols: Work within the whole-brain-death standard, by developing medical cooling[586] or ventilator support[587] protocols, in an attempt to maximize the likelihood of successful organ procurement.

(4) Special Category: Consider living anencephalic newborns to be a special category of beings — non-persons, who warrant special treatment.

The customary-care and medical-protocol options generally involve medical practices. While the legal issues they raise are not negligible, many of them may be addressed by examining the brain-death and special-category proposals.

(1) Redefining Brain Death

The proposals to deem live-born anencephalic infants to be brain dead, brain absent, stillborn, or exempt from the brain-death standard invite reconsideration of the brain-death standard. In doing so, they also invite modification or reaffirmation of the purpose, functions and principles underlying the existing whole-brain-death standard.

It has been twenty years since the first landmark proposal was made in North America to change the traditional definition of death from heart and lung cessation to the irreversible

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581. Shewmon et al., *supra*, note 575 at 1778.

582. See Conference of Medical Royal Colleges (Great Britain), The Working Party on Organ Transplantation in Neonates" (1988) 14:3 J. Med. Ethics 164 ("In the adult the diagnosis of brain death plus apnoea is recognised as death. The working party felt by analogy that the absence of the forebrain in these infants plus apnoea would similarly be recognised as death.").

583. Scott, *supra*, note 579 at 1565. See also Jay A. Friedman, "Taking the Camel by the Nose: The Anencephalic as a Source for Pediatric Organ Transplants" (1990) 90 Colum. L. Rev. 917.

584. Michael R. Harrison, "The Anencephalic Newborn as Organ Donor" (1986) 16:2 Hast. Cent. Rep. 21.

585. See Bernard M. Dickens, "The Infant as Donor: Legal Issues" (1988) 20:4 (Supp. 5) Transplant. Proc. 50 at 52.

586. A. Kantrowitz et al., "Transplantation of the Heart in an Infant and an Adult" (1968) 22:6 Am. J. Cardiology 782.

587. See Peabody et al., *supra*, note 580.

cessation of all brain functions.[588] Like the old definition, the new definition was based on the medical technology and needs of the day. Mechanical respirators and circulators had joined the stethoscope as standard tools of medicine. Yet, if a patient could be maintained indefinitely on an artificial respirator and have no responsiveness and no brain functions, what was the legal status of the patient? Under traditional definitions of life and death, both law and medicine tended to regard the patient as alive, despite the absence of spontaneous respiration and circulation.

In 1970, Kansas became the first North American jurisdiction to pass a law adopting a brain-death definition.[589] Manitoba legislatively adopted a brain death definition in 1975.[590] By the time that the Law Reform Commission of Canada studied the issue five years later, a medical, legal and ethical consensus had largely emerged in North America that the irreversible cessation of all brain functions was the equivalent of the death of the person. The new standard was designed to supplement the traditional standard. Today, Canadian criminal case law,[591] the amended uniform tissue law[592] and the medical

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588. Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, "A Definition of Irreversible Coma" (1968) 205:6 JAMA 337.

589. Kan. Stat. Ann. s. 77-202 (1970).

590. *The Vital Statistics Act*, R.S.M. 1987, c. V60.

591. See *Kitching*, *supra*, note 565. But see *R.* v. *Green* (1988), 43 C.C.C. (3d) 413 (B.C.S.C.). Green involved the rather "exceptional" circumstances of a defendant claiming that he could not be charged with murdering someone already dead. See Stuart, *supra*, note 506 at 109. Defendant Green had fired two shots into a victim's head, shortly after another defendant had first shot the victim in the head. Apparently all three shots, if fired alone, would have proved fatal. Green's claim that the victim was already dead presented the court with a legal question over the time and determination of death for purposes of liability for homicide. When the time of death is legally controverted, courts properly attempt to resolve the question on the basis of expert medical testimony. See *Defining Death*, *infra*, note 594 at 78.

In *Green*, the court rejected applying brain-death criteria to help answer the question. It chose to use the traditional criteria for death — heart/lung cessation — for two apparent reasons. First, there was some indication that while the victim had stopped breathing after the first shot, his heart may have still been beating when he received defendant Green's two shots. Secondly, owing apparently to brain trauma the victim had suffered, the court seemed concerned that the Crown might not be able to prove that the victim was still alive ("brain alive") if the brain-death standard were used. The court characterized brain-death criteria as "a completely impractical standard to apply in the criminal law."

The medical evidence presented in the case is limited. Still, we would emphasize three points about "brain death." First, the LRC proposal refers to *whole* brain death (versus brain death), and the irreversible cessation of brain functions (versus brain function). Secondly, under the LRC standard, whole brain death may "be determined by the prolonged absence of spontaneous circulatory and respiratory functions." See Report 15, *supra*, note 1. Depending on the precise medical facts, then, a beating heart may be evidence that whole brain death has not occurred. See *Defining Death*, *infra*, note 594 at 15.

Thirdly, Canadian, British and American courts have, in fact, adopted the brain-death standard to aid in determining the time and cause of death in more typical modern homicide cases: namely, when a homicide victim enters an emergency room of the hospital, is placed on mechanical life support which is withdrawn after the pronouncement of death, and the defendant argues that the withdrawal of life support was either the cause, or determined the time, of death. *Kitching*, *supra*, note 565; *R.* v. *Malcherek*; *R.* v. *Steel*, [1981] 2 All E.R. 422; *Eulo*, *supra*, note 565. See generally David B. Sweet, "Homicide by Causing Victim's Brain-Dead Condition" 42 A.L.R. 4th 742. The courts' uniform rejection of defendants' arguments in these cases, and their adoption of the brain-death standard to clarify the cause or time of death, would seem to indicate that the brain-death standard does prove helpful in establishing liability in homicide cases. Fuller examination of such criminal liability concerns may be afforded by future cases and commentary.

592. See *infra*, note 835.

profession[593] have adopted a brain-death standard. Some forty-nine jurisdictions in the United States[594] and most of Western Europe[595] have similarly done so.

A primary purpose behind the whole-brain-death standard was to clarify legal rights and duties with a legal standard more consonant with the times. A clear definition of death reduces uncertainty and confusion over when a person is legally dead. It gives families a contemporary societal standard for making difficult decisions concerning treatment and non-treatment; it clarifies professional duties, patient rights and the limits of criminal liability. A clear definition of death thus facilitates organ procurement and transplantation.

The Law Reform Commission of Canada was convinced that a reform of the legal standard of death should adhere to several legal and public policy principles. First, the reform must be aimed at eliminating confusion; it should provide clarity and guidance to professionals and the lay public.[596] Secondly, it must advance uniformity and apply equally in all circumstances in which the determination of death is at issue.[597] This principle borrows from the reliability and uniformity of the traditional heart-lung cessation standard, and aims to reduce a proliferation of conceptions and definitions of death, which would foster confusion. As the U.S. President's Commission has stated, a new standard "ought not to reinforce the misimpression that there are different 'kinds' of death, defined for different purposes, and hence that some people are 'more dead' than others."[598]

Thirdly, the reform must "recognize standards and criteria generally accepted by the Canadian public."[599] The consensus-building process that had unfolded in North American society in the decade before the Commission announced its proposal meant that the public had already benefitted from the debate and deliberations of the medical, legal and bioethical community on a brain-death standard of death. The acceptability principle, in fact, was an influential factor in the Commission's view that adoption of a higher-brain-death standard would be ill-advised:

> In the opinion of the Commission, many members of the public and many professionals are definitely not prepared to consider as dead a person whose cortex [brain] is irreversibly destroyed, but who still enjoys spontaneous cardiac and respiratory functions. The Karen Quinlan case in the United States appears to be a good illustration of that point.[600]

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593. Canadian Congress on Neurological Sciences, *supra*, note 194; Canadian Congress Committee on Brain Death, *supra*, note 194.

594. See New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care, *Problems and Approaches in Health Care Decision-Making: The New Jersey Experience* (New Jersey: The Commission, 1990) at 11. The New York State Task Force on Life and the Law, *The Determination of Death*, 2d ed. (New York: The Task Force, 1989) at 4 [hereinafter NYTF]. See generally President's Commission, *Defining Death: A Report on the Medical, Legal and Ethical Issues in the Determination of Death* (Washington, D.C.: The Commission, 1981) [hereinafter *Defining Death*].

595. See chap. 4, section II.C, below.

596. LRC, *Criteria for the Determination of Death*, Working Paper 23 (Ottawa: Supply and Services Canada, 1979) at 51.

597. *Ibid.* at 53.

598. *Defining Death*, *supra*, note 594 at 60.

599. Working Paper 23, *supra*, note 596 at 55.

600. Report 15, *supra*, note 1 at 16.

Karen Ann Quinlan, who lay in a persistent vegetative state with no likelihood of recovery and whose parents requested court permission to turn off her respirator, had lost higher brain functions but retained brain-stem activities.[601] Whereas patients who are brain dead can neither breathe spontaneously nor respond to light, pain and sound stimuli, patients having lower brain-stem activities do breathe spontaneously.[602] Indeed, after the removal of life support, Karen lived for years. Today, there is still no consensus in North American or even in Canadian society that higher brain death is or should be equated with the death of the person.[603] Adoption of a higher-brain-death standard would mean that anencephalic newborn infants and an estimated 1,000 to 10,000 patients who, like Karen Quinlan, lie in a persistent vegetative state in Canada would become candidates for organ donation, although they enjoy spontaneous heart and lung activity.[604]

Finally, the Commission was and still is of the opinion that the criteria for death should not be determined "by reference only or mainly to the practice of organ transplantation."[605] The neutrality principle — that the reform be conceived neither to hinder nor to aid organ transplantation — recognizes the equality of other legitimate competing social interests in the determination of official death and seeks to avoid undue bias in the definition of death.

These principles bear directly on current considerations to exempt anencephalic newborn infants from, or to amend, the whole-brain-death standard. Such proposals violate the neutrality principle because they are motivated specifically to aid organ procurement from a class of severely disabled newborns. Organ transplant benefits alone do not justify shifting the life-death criteria because, beyond its medical implications, death is also a theological, moral and legal concept.[606] A redefinition based simply on organ transplant needs, moreover, may create the impression of arbitrariness and unequal treatment, because the law may appear to be trading the interests of potential organ recipients against the interests of severely disabled infants and their families.[607] Leading medical texts have,

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601. *Re Quinlan*, 355 A. 2d 647 (N.J. 1976), cert. denied 429 U.S. 922. For the recent landmark sequel to Quinlan, see *Cruzan* v. *Missouri*, 110 S. Ct 2841 (1990).

602. See B. Young, W. Blume and A. Lynch, "Brain Death and the Persistent Vegetative State: Similarities and Contrasts" (1989) 16:4 Can. J. Neurol. Sci. 388; American Medical Association, Council on Scientific Affairs and Council on Ethical and Judicial Affairs, "Persistent Vegetative State and the Decision to Withdraw or Withhold Life Support" (1990) 263:3 JAMA 426; American Academy of Neurology, "Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient" (1989) 39:1 Neurology 125.

603. See NYTF, *supra*, note 594 at 10.

604. See Taylor, *supra*, note 250. See also David Randolph Smith, "Legal Recognition of Neocortical Death" (1986) 71 Cornell L. Rev. 850.

605. Report 15, *supra*, note 1 at 12; Working Paper 23, *supra*, note 596 at 56.

606. NYTF, *supra*, note 594 at 6. But see Edward W. Keyserlingk, "A Legal Definition of Death: Can It Affect Supply of Tissue and Organs?" (1985) 17:6 (Supp. 4) Transplant. Proc. 47 at 48-49 ("None of which is to deny that organ transplantation claims are a major, if not the major, justification and reason for these statutes. Nor is there any good reason for the frequently expressed or implied fear that it is somehow unethical that this should be so. After all, as has been observed, preserving life and health is the highest of values in our society, transplanting organs is one way of achieving those goals in some cases.").

607. See "World Medical Association Adopts Declarations and Statements on Bioethical and Other Matters" (1988) 39:1 Int'l Dig. Health Leg. 267, excerpted in appendix A, *infra* at 200-201. ("A potential organ transplant offers no justification for a relaxation of the usual standard of medical care. The same standard of care should apply whether the patient is a potential donor or not.").

for years, referred to anencephalic children as monsters.[608] Given the evolving and heightened attitudes on the rights and protections of minimally or severely disabled individuals, shifting the legal criteria for the determination of death for a particular class of patients "raises troubling questions about evaluating the quality of life as part of the determination of death."[609] In the extreme, such an amendment also raises serious legal questions over whether some deaths and some brains are "more equal than others,"[610] and whether it would subject anencephalic infants to unjustified discrimination on the basis of physical disability.[611] These concerns underscore the need for reforms consistent with, and not violative of, basic human rights.

Secondly, the enactment of such proposals is not likely to clarify or help dispel lingering confusion over the existing brain-death standard. A disturbing minority of health professionals who work in the area still evidence confusion over the diagnosis and determination of brain death.[612] Changing the definition of death to apply to one group of patients may thus undermine uniformity, begin a proliferation of standards of death and foster confusion about which criteria do and should apply to what group of patients:

> As society contemplates the expansion of the potential donor pool to include other brain-damaged patients, who are clearly alive by today's legal and medical standards, the confusion may be compounded. Those who have accepted the whole-brain criterion because they have a higher brain concept or merely think brain dead patients are hopelessly dying may find it acceptable to take organs from certain patients currently defined as living, e.g. anencephalics or patients in persistent vegetative state, because such patients have clinical characteristics that are compatible with a less conservative concept of death. Some might seek to change the legal standards for death, thereby removing any obstacle to using other types of severely brain-damaged patients as donors. Without a greater consensus on a concept of death, such "conceptual gerrymandering" will only sow further confusion about, and perhaps resistance to, organ retrieval.[613]

Thirdly, then, a change will not satisfy the acceptability principle. That the medico-legal literature on anencephalic infants abounds with brain-absent, brain-dead and born-dead proposals suggests that medicine, bioethics and the law are still in the early phases of seeking a consensus on the legal and moral status of anencephalic infants. While the diversity of opinions, interests and alternatives is necessary for and healthy to proper debate on the

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608. Compare Pritchard, MacDonald and Gant, *supra*, note 571 at 802 ("monster") and F. Gary Cunningham, Paul C. MacDonald and Norman F. Gant, eds, *Williams Obstetrics*, 18th ed. (Norwalk, Conn.: Appleton & Lange, 1989) at 575 ("child"). See generally James W. Walters, "Are Anencephalic Infants Monstrosities?" (1989) 2:28 BioLaw S:211.

609. NYTF, *supra*, note 594 at 10.

610. B. Freedman, "The Anencephalic Organ Donor: Affect, Analysis, and Ethics" (1988) 20:4 (Supp. 5) Transplant. Proc. 57 at 61.

611. See section IV, below.

612. Stuart J. Youngner et al., "'Brain Death' and Organ Retrieval: A Cross-sectional Survey of Knowledge and Concepts among Health Professionals" (1989) 261:15 JAMA 2205 (of 195 health professionals surveyed, 35% correctly identified brain death, 58% failed to use a coherent concept of death consistently, 19% had a concept of death consistent with changing whole-brain standard to classify anencephalic infants and PVS patients as dead). See also ONT, *supra*, note 29 at 235.

613. Youngner et al., *supra*, note 612 at 2210.

issue, it provides little basis for erecting a new legal standard. The lack of consensus at this societal juncture also means that adoption of any of the current alternatives would not be based on "standards and criteria generally accepted by the Canadian public."[614] For by either the traditional heart-lung or more modern whole-brain-death criteria, a live-born, severely neurologically impaired anencephalic infant is born living:

> Manipulating the definition of death — by including anencephalic infants, whose spontaneous breathing, sucking, crying, and the like separate them from the dead bodies that society is usually willing to label cadavers and bury — may undermine the public's already tenuous confidence in brain-based determinations of death. The predictable result will be a decline in the donation of organs from all categories of potential donors, as occurred in England following a highly publicized television program that called into doubt the accuracy of brain-death diagnoses.[615]

Some might be inclined to dismiss such remarks as overstatement. Yet, there is evidence that the public is reluctant to participate in the organ donation process, in part, because of fear about premature determination of death.[616] While the standard of death may work to facilitate organ transplantation, undue bias in the standard setting may itself erode public confidence in both the law and the organ donation process.[617] Thus, concern about the relationship between medical practice, the legal definition of death and the public's confidence and willingness to participate in the organ donation process is legitimate. The delicacy of that relationship itself would seem to suggest prudence and caution.[618]

(2) Redefining Persons

The opportunity to bring about an immediate, tangible good for potential recipients and for the donor parents, and the apparent "lack of harm" to the anencephalic infant, prompt some analysts to assign them a unique status:

> [I]nfants born with the top half of their brains missing are so very different from other living infants — and their future so radically limited — that it is permissible, with the fully informed and freely given consent of the parents, to remove their organs for transplantation. "... anencephaly is a condition so special, so very different from all others ... that infants in this most unfortunate condition should be viewed as in a class that is entirely *sui generis*, and one for which special rules and laws should apply."[619]

This approach would permit organs to be taken although the criteria for brain death are not satisfied.

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614. See Report 15, *supra*, note 1 at 12; Working Paper 23, *supra*, note 596 at 55.

615. Shewmon et al., *supra*, note 575 at 1778.

616. See Nolan and Spanos, *supra*, note 225. See also U3TF, *supra*, note 29, and Areen, *supra*, note 226 at 562.

617. Even apart from possibly slighting other legitimate legal interests that are influenced by the determination of death, such as inheritance rights, criminal law prosecution, civil suits and withdrawing artificial life support for non-transplant purposes. See Keyserlingk, *supra*, note 606 at 47-48.

618. Accord, *Defining Death*, *supra*, note 594 at 58-59.

619. Ethics and Social Impact Committee Transplant Policy Center, "Anencephalic Infants as Sources of Transplantable Organs" (1988) 18:5 Hast. Cent. Rep. 28 [hereinafter ESIC].

From the criminal law perspective, the special-category option raises several general concerns. On the one hand, the Commission's view that it may sometimes be acceptable to withdraw "therapeutically useless" care[620] from and to administer palliative, life-shortening care[621] to the dying may offer guidance in treatment decisions. On the other hand, the Commission has expressed its views on the criminal law as proposed reforms; they remain unenacted. Accordingly, medical treatment that causes[622] or accelerates death,[623] or that involves a premature diagnosis of death[624] for any living human being, risks running afoul of the existing *Criminal Code*.[625]

In such instances, it has been suggested that the medical status of the anencephalic infant and the life-saving purposes of the initiative might establish a "necessity" defence to excuse criminal liability.[626] Others are unpersuaded by the argument.[627] The tenor of the criminal liability concerns and the general difficulty of applying brain-death criteria to anencephalic and other newborns[628] would seem to undermine the utility of designing and medically implementing a special-category option.

The special-category option also raises ethical concerns[629] involving a clash between beneficence and non-maleficence, and contested views on the relation between the body and self.

In terms of the ethical duty to do good, the special-category approach may hold promise. For potential recipients, although the long-term success and quality of life of infant

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620. LRC, *Euthanasia, Aiding Suicide and Cessation of Treatment*, Report 20 (Ottawa: Supply and Services Canada, 1983) at 27-28.

621. Report 31, *supra*, note 116 at 60.

622. See *Kitching*, *supra*, note 565. See also *Criminal Code*, s. 269 (unlawfully causing bodily harm).

623. *Criminal Code*, s. 226: Acceleration of Death—

> Where a person causes to a human being a bodily injury that results in death, he causes the death of that human being notwithstanding that the effect of bodily injury is only to accelerate his death from a disease or disorder arising from some other cause.

624. See *Eulo*, *supra*, note 565, and *Kitching*, *supra*, note 565.

625. Some of these concerns may also apply to the medical protocols option.

626. See M.J. Tuttle, "Transplanting Organs from Anencephalic Infants" (letter) (1987) 136:8 C.M.A.J. 797. See also Diana Brahams, "Fetal Spare Parts" (1988) 1:8582 Lancet 424. For discussion of the necessity and public policy defences, see Working Paper 26, *supra*, note 370 at 42, 61.

627. See Dickens, *supra*, note 585 at 51 ("It is doubtful that causing homicide by precipitation of death of an anencephalic could be justified or excused by the defense of necessity to save the recipient's life. The wrong done must be objectively minor in comparison with the benefit sought, but even saving a salvageable life of a child may be insufficient to excuse ending the life of another, even an anencephalic likely to die relatively soon thereafter.").

628. See MTFA, *supra*, note 570 at 672; Canadian Congress on Neurological Sciences, *supra*, note 194 at 200B ("Brain death has not been sufficiently well studied in neonates, infants and young children to determine whether the clinical criteria listed above apply to these groups"). See also Task Force for the Determination of Brain Death in Children, "Guidelines for the Determination of Brain Death in Children" (1987) 37 Neurology 1077; David L. Coulter, "Neurologic Uncertainty in Newborn Intensive Care" (1987) 316:14 N. Engl. J. Med. 840.

629. As indicated above, the ethical aspects of organ procurement from anencephalic newborns are discussed here to provide a more concentrated analysis.

transplants remain uncertain,[630] the initiative may still mean life. For parents, the opportunity to donate the organs of their dying anencephalic child to help save life likely offers them solace and some meaning from the tragedy. Such prospective benefits appear compelling.

The above-mentioned benefits may not prove conclusive, however, as detractors are quick to underline, because of the possible related harms. Possible harm springs from medical-ethical uncertainty, slippery-slope concerns and potential intrinsic moral wrongs associated with categorizing anencephalic infants as non-persons. First, claims that[631] "[a]nencephalic infants lack the neurologic capacity to feel pain,"[632] and that the diagnosis of anencephaly is determined with near 100-per-cent accuracy[633] are not beyond dispute. Leading authorities agree that the diagnosis of anencephaly is not infallible, but is best made following precise criteria.[634] The claim that anencephalic newborns have no capacity to feel pain, moreover, rests on a comparison of them with older patients in a persistent vegetative state[635] — a comparison that some continue to question.[636] Analysts also argue that because anencephaly leaves some newborns with more intact brain-stems than others, degrees of consciousness or unconsciousness may vary.[637] Doubt about these medical premises may make potential harms to anencephalic newborns more appreciable than some special-category enthusiasts would seem to allow. To the extent that the medical premises of the position present problems, those problems may infect the ethical analysis.[638]

Secondly, the special-category proposal raises consequentialist concerns. Will the procuring of organs from newborns before they are dead undermine public confidence in the procurement and transplant process?[639] Will women diagnosed with an anencephalic fetus find their autonomy compromised by pressure to carry the fetus to term for transplant purposes? Will it lead to a denial of the respect ordinarily given to non-disabled infants and parents?[640] If anencephalic newborns are deemed non-persons, will other individuals

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630. See Abbyann Lynch, "Use of the Anencephalic Infant as Organ Donor: Some 'Public' Questions" (1988) 1:2 Westminster Aff. 1 at 3. Compare Frewen et al., *supra*, note 579.

631. D. Alan Shewmon, "Anencephaly: Selected Medical Aspects" (1988) 18:5 Hast. Cent. Rep. 11 at 14.

632. Arthur L. Caplan, "Ethical Issues in the Use of Anencephalic Infants as a Source of Organs and Tissues for Transplantation" (1988) 20:4 (Supp. 5) Transplant. Proc. 42 at 47. See also Robert C. Cefalo and H. Tristram Engelhardt, "The Use of Fetal and Anencephalic Tissue for Transplantation" (1989) 14:1 J. Med. Phil. 25 at 32.

633. Caplan, *supra*, note 632 at 48; ESIC, *supra*, note 619 at 29.

634. See MTFA, *supra*, note 570 at 670; Shewmon, *supra*, note 631 at 15.

635. Shewmon, *supra*, note 631 at 14.

636. See MTFA, *supra*, note 570 at 672; Shewmon, *supra*, note 631 at 14; Young, Blume and Lynch, *supra*, note 602 and K.J.S. Anand and P.R. Hickey, "Pain and Its Effects in the Human Neonate and Fetus" (1987) 317:21 N. Engl. J. Med. 1321. Anesthesia is generally not used for those considered brain dead. Thomas Leggans, "Anencephalic Infants as Organ Donors" (1988) 9:3 J. Legal Med. 449 at 460-61.

637. See Shewmon, *supra*, note 631 at 15.

638. *Ibid.* at 14.

639. See, *e.g.*, Caplan, *supra*, note 632 at 43-44. See also *supra*, notes 225-227.

640. See Leggans, *supra*, note 636 at 455.

also lose their status as human beings, to slip into an expanded organ donor pool? Potential candidates include infants with other neurological malformations (for example, spina bifida and hydrencephaly), severely mentally retarded persons[641] and the Karen Anne Quinlan type of hospital patients who, although not brain-dead, lie in a persistent vegetative state.[642]

Lastly, treating anencephalic infants as a special category may raise intrinsic wrongs by violating a Kantian-inspired ethical duty.[643] The injunction — treat people as ends and never as means alone — applies to potential recipients, health professionals, parents of anencephalic newborns and society at large. Proponents of anencephalic infant organ procurement argue that the duty to respect persons does not apply to these infants, because of their "uncertain moral status."[644] The claim rests on a view that moral respect is owed to "persons," not merely because they are members of the human species, but because of their "sentience, consciousness, or self-awareness,"[645] and "the capacity for autonomy and choice."[646] The claim is buttressed by the further argument that since anencephalic newborns lack mental capacities that generate interests, they have none or few of the interests that usually command respect:

> [I]t becomes difficult to know how to interpret the desire to respect the interests of such children. Those who wish to respect the dignity of all human beings must show why such a principle is violated when it is not extended toward children who lack any possible means of having interests.[647]

Thus, the duty to respect persons has been reduced to the duty not to harm persons by infringing their interests[648] — that is, to the duty of non-maleficence.[649]

Paralleling the ethical debate over harms to the dead, proponents and detractors of the special-category or non-person approach to anencephalic newborn organ procurement

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641. *Ibid.* at 640, and Lynch, *supra*, note 630 at 2.

642. See "New Arguments Voiced over Use of Anencephalics as Organ Donors" (May/June 1989) Hosp. Ethics 6 [hereinafter New Arguments]. If the moral bases of tissue procurement are considered to be "to assure respect for autonomous choice, voluntarism, and deliberative rationality while at the same time preventing serious harm to the donor," then it is hard to see how extensions to these other classes of "donors" could be resisted. See Caplan, *supra*, note 632 at 46.

643. New Arguments, *supra*, note 642 at 7. See also chap. 2, above.

644. Caplan, *supra*, note 632 at 47.

645. *Ibid.* at 48; Leggans, *supra*, note 636 at 455; New Arguments, *supra*, note 642 at 6-7. See also ESIC, *supra*, note 619 at 29.

646. Caplan, *supra*, note 632 at 48. But see Freedman, *supra*, note 610 at 57. ("People, it is believed, are valuable; and the quality which distinguishes people — from each other, as well as from other species — is mentation. It does not follow that all human worth is owing to mentation. That which distinguishes a species need not characterize the individual. In the case of humans incapable of mentation, other sources of value come to the forefront — factors which, for those of normal capacities, are obscured in the blinding light of mentation.").

647. Caplan, *supra*, note 632 at 48.

648. See also Cefalo and Engelhardt, *supra*, note 632 at 35-36.

649. This parallels the argument that dead persons cannot be harmed because, not being sentient, they have no interests that can be infringed. See chap. 2, section I.C, above. If anencephalic infants are morally no different than the dead, then why not treat them as if they were dead?

seem to differ fundamentally in their views on the relation between the body and self.[650] Proponents tend to reduce persons to their sentient or cognitive capacities, by equating persons with their rational selves. The body tends to become morally irrelevant. Those reluctant about taking organs from anencephalic infants seem more inclined to view persons as embodied selves, wherein moral respect is owed to the body as well as to its sentient, rational attributes. A conception of persons as embodied selves[651] may not be amenable to rational justification, because the respect it accords the body likely derives from fundamental sentiments that transcend rational argument.[652]

In all, currently declining the options to create a special category of "non-persons" and declining to amend the brain-death criteria essentially means that anencephalic infants will generally be treated like other potential organ "donors."[653] This still leaves medicine free to explore potential benefits from tissue and organ transplantation from anencephalic infants through the customary-care and reasonable-medical-protocols options.[654]

C. Deceased Donors and Crimes against the Dead

Criminal law protects interests and defines duties regarding the dead. Historically, criminal law has for centuries played the dual role of mandating respect for the dead human body and of directly contributing to the supply of dead human bodies for medical science purposes. Indeed, the existing *Criminal Code* offence[655] of improper interference with or offering indignities to the dead derives from that tradition. The tradition has now begun to exert its influences in the modern context of the procurement and transplant process, which depends on the dead as the major source of donated organs.

(1) Dissecting and Donating as Punishment

An American doctor recently proposed that condemned prisoners pay their debts to society by donating organs for transplantation upon execution.[656] The proposal to supply medical science with the bodies or bodily parts of the malefactors of society has historical

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650. *Ibid.*

651. For Caplan, this conception seems to be tantamount to incorrectly predicating moral respect on the basis of mere membership in the human species. *Supra*, note 632 at 48. See also Cefalo and Engelhardt, *supra*, note 632 at 38.

652. See, *e.g.*, Freedman, *supra*, note 610 at 57. See also chap. 2, section I.B, above.

653. "[T]here are no sound reasons for treating newborns with anencephaly as a qualitative exception to transplantation practices." Freedman, *supra*, note 610 at 63. Accord, Canadian Pediatrics Society, Bioethics Committee, "Transplantation of Organs from Newborns with Anencephaly" (1990) 142:7 C.M.A.J. 715 ("The criteria and ethical principles that apply to organ transplantation involving children and adults also apply to the newborn, as either recipient or potential donor").

654. This appears to be the course that will be adopted at the Children's Hospital of Western Ontario. See Dahlia Reich, "Organ Donations: Brain Death Guidelines to Be Tested" *The London Free Press* (23 August 1989) A1.

655. For a discussion of *Criminal Code* s. 182(*b*), see text accompanying note 675, *infra*.

656. B.-J. C., "An Eye for an Eye" (1989) 19:2 Hast. Cent. Rep. 3.

precedent. The idea dates from the third or fourth century B.C. when, at the University of Alexandria, bodies of executed criminals were supplied to university physicians for the study of anatomy.[657] Even the vivisection of condemned criminals was practised.[658]

The approach of using the criminal law to provide bodies for human dissection eventually made its way to Europe and North America. In 1376, King Louis d'Anjou granted the University of Montpellier permission to receive one executed criminal annually for dissection.[659] When the London Barber-Surgeons' Guild received its Royal Charter in 1540, the Act uniting the two crafts authorized the Guild to receive four executed felons annually for dissection and anatomical study.[660] The law gave the Guild the exclusive right to conduct anatomical demonstrations, and the United Company of Barbers and Surgeons "jealously guarded" the privilege for some 175 years.[661] As anatomical practice eventually became the sole province of surgeons and physicians, the number of bodies of executed criminals was later increased from four to include all murderers executed in London and Middlesex.[662]

The purpose behind such laws appears to have been twofold. First, it appears that some of the laws were intended to add dissection as a "peculiar infamy" to the punishment for murder.[663] This purpose was expressed in the Lord Justice-Clerk's 1829 sentencing of William Burke, who was convicted and executed for murdering several individuals whose bodies he sold to Scottish anatomists:

> William Burke, You now stand convicted, by the verdict of a most respectable Jury of your country, of the atrocious murder charged against you in this indictment . . . if ever it was clear, beyond all possibility of a doubt, that the sentence of a Criminal Court will be carried into execution, in any case, yours is that one, . . . I am disposed to agree that your sentence shall be put in execution in the usual way, but accompanied with the statutory attendant of the punishment of the crime of murder, viz. — that your body should be publicly dissected and anatomized. And I trust, if it is ever customary to preserve skeletons, yours will be preserved, in order that posterity may keep in remembrance your atrocious crimes.[664]

The surgeon to whom Burke had supplied many of the bodies performed a public dissection of Burke, whose skeleton may now be viewed at the University of Edinburgh Anatomy Department. It stands as an irony of history that one of the most infamous criminals in the trafficking of dead bodies for anatomical study in the nineteenth century was ultimately

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657. See Kevorkian, *supra*, note 17 at 20-22.

658. *Ibid.*

659. Lassek, *supra*, note 15 at 81.

660. *For Barbers and Surgeons* (U.K.), 32 Hy. 8, c. 42.

661. Ball, *supra*, note 19 at 59.

662. See *An Act for better preventing the horrid Crime of Murder* (U.K.), 25 Geo. 2, c. 37, as rep. 9 Geo. 4, c. 31. See also Ball, *supra*, note 19 at 63.

663. See Frederick C. Waite, "The Development of Anatomical Laws in the States of New England" (1945) 233:24 N. Engl. J. Med. 716 at 717, quoting Preamble to the 1752 Act.

664. See D. William Roughead, *Burke and Hare* (Toronto: Canada Law Book, 1921) at 256-57.

snared and punished by provisions permitting the dissection of criminals executed for murder. The punishment purpose is echoed in the recent proposal that executed criminals in the United States serve as organ sources.[665]

A secondary purpose of such criminal law provisions was to help provide medical science with bodies, which were in scarce supply. Not surprisingly, some of the settlers in the New World brought this cultural and legal tradition with them. Thus, a law to supply the bodies of executed criminals for anatomical dissection was enacted in the Massachusetts Bay Colony in the mid-1600s.[666] The practice was adopted into federal criminal law in the United States and remained in effect until 1987.[667] It was also considered in Canada,[668] although there is no apparent evidence that the practice was pursued.[669] While the supply theory behind the enactment of such laws may have relevance to current organ scarcity in Canada, the general abolition of the death penalty in the 1970s means that the proposal can have little current application in Canadian society.[670]

(2) Mistreating and Stealing the Dead

Humankind has long accorded respect to the dead human body and its remains.[671] Although the bodies of some non-citizens or *persona non grata* have, on occasion, not benefited from such respect,[672] the general attitude is reflected in the burial customs, religious practices and moral customs of Western civilization. The criminal law has not escaped these influences. In a nineteenth-century criminal case involving the neglected burial of a child, a Canadian judge echoed these sentiments by stating that "[e]very dead human body is entitled to a decent burial."[673]

Today, the Canadian *Criminal Code* requires respectful treatment of the dead. In doing so, it reflects abiding and evolving attitudes on respect for the dead. It specifically

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665. See *supra*, note 656.

666. Waite, *supra*, note 663 at 717.

667. See 35 Stat. 1152 (codified at 18 USC 3567), as rep. P.L. 98-473, Title II, c. II, § 212(a) (1) and P.L. 99-217, § 4, 99 Stat. 1728.

668. See Debates, *infra*, note 803 at 467 n. 33, discussing *Anatomy Act* debates.

669. The first federal criminal law of Canada, in 1869, simply provided that criminals sentenced to death be executed "in the manner provided by law." Their bodies were to be buried within the prison walls, *An Act respecting Procedure in Criminal Cases, and other matters relating to Criminal Law*, 32 & 33 Vict., c. 29, ss 106, 117.

670. See *An Act to amend the Criminal Code*, S.C. 1973-74, c. 38, ss 2, 3; *Criminal Law Amendment Act (No. 2), 1976*, S.C. 1974-75-76, c. 105 (abolishing death penalty for *Criminal Code* offences). The death penalty theoretically remains for military personnel convicted of treason and like conduct. See *National Defence Act*, R.S.C. 1985, c. N-5, ss 73, 74, 139, 203, 206, *inter alia*.

671. See generally Lassek, *supra*, note 15 at 20.

672. Kevorkian, *supra*, note 17 at 26 ("Slaves were no different to the Romans than mere material objects of their environment; and killing a slave was not murder, but simply damaging an object. Dead slaves and prisoners of war were often left unburied and thus offered a good source of material for the sporadic dissections which were done.").

673. *R.* v. *Newcomb* (1898), 2 C.C.C. 255 at 256 (N.S. Co. Ct).

reflects societal expression of the Judeo-Christian tradition of according decent burials to the dead, by making it an offence to neglect, without lawful excuse, one's burial duties.[674]

The *Criminal Code* also penalizes indignities to or indecent interferences with a dead body or human remains:

> Everyone who ...
>
> (*b*) improperly or indecently interferes with or offers any indignity to a dead human body or human remains, whether buried or not,
>
> is guilty of an indictable offence ... .[675]

There are several overlapping purposes behind the provision. It expresses the long-held view that the dead human body is entitled to respect. Furthermore, it expresses respect for the emotional and religious sentiments of the next of kin and the moral tranquillity of society at large. In practical terms, the provision aims at preventing physical abuse of the dead body, protecting the public health and minimizing public nuisances. A review of the common law heritage of Canada, Great Britain and the United States shows how courts have articulated these purposes in cases involving sales of bodily parts, sexual indecency and theft, and even in the more modern contexts of medical experimentation.

Concern over the moral integrity of the community has been a traditional basis in definitions of criminal mistreatment of the dead body or human remains. Leading British jurists and Continental thinkers of the eighteenth and nineteenth century regarded the mistreatment of corpses as a high moral offence.[676] The existing Canadian offence derives directly from an unenacted 1879 draft British criminal code, which essentially codified British common law criminal misdemeanours against dead bodies.[677] While preventing the commission of sexual indecencies[678] upon the dead is an example of the obvious moral

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674. *Criminal Code*, s. 182(*a*). The Commission has proposed that the failure-to-bury provision be repealed, as archaic. See Report 31, *supra*, note 116 at 102.

675. *Criminal Code*, s. 182(*b*).

676. See James Fitzjames Stephen, *A Digest of the Criminal Law: Crimes and Punishments*, 4th ed. (London: Macmillan, 1887) art. 175 (morality offence); William Blackstone, *Commentaries on the Laws of England. Book the Fourth* (Oxford: Clarendon Press, 1779) at 236 ("a matter of great indecency"). Compare 1983 *Criminal Code Act* of Northern Territory of Australia, art. 140 (misconduct regarding corpse as morality offence); *New Zealand Crimes Act, 1961*, s. 150 (crimes v. human remains and crime against person); and crimes against sepulchres, under s. 360 of the French Penal Code. As a morality offence, s. 360 has broadly been interpreted to extend to the cemetery monuments, buried bodies, and bodies not yet buried, *Code pénal*, 88th ed. (Paris: Dalloz, 1991). See Dickens, *supra*, note 382, para. 311. In this respect, see also the potential use of French criminal assault and battery provisions, *infra*, note 717.

677. See U.K., Criminal Code Bill Commission, *Report of the Royal Commission Appointed to Consider the Law Relating to Indictable Offences* (London: HMSO, 1879) at 22 ("sections 153 and 158 are declaratory of the common law"); Stephen, *supra*, note 676 at 117, 122; *The Criminal Code*, 55 & 56 Vict., c. 29, s. 206. For a general description of the first 100 years of the Canadian *Criminal Code*, see Alan W. Mewett, "The Criminal Law, 1867-1967" (1967) 45 Can. Bar Rev. 726.

678. *R.* v. *Ladue*, [1965] 4 C.C.C. 264 (Y.T.C.A.).

basis of the existing criminal offence, the common law crime actually arose in the context of supplying dead bodies for medical science.[679] In the 1788 English case that established the rule, a man was fined five marks for unburying a dead body he intended to sell to a doctor for anatomical dissection.[680] The historic no-property-in-a-corpse view meant that the man could not be convicted of having stolen the body.[681] Nor was unburying a dead body for dissection found by the court to be explicitly forbidden by a law prohibiting disinterment for purposes of witchcraft.[682] Still, the court found the practice highly indecent, against good morals (*contra bonos mores*), and therefore a criminal offence. The case illustrates how the common law historically sought to prevent the sale of dead bodies: namely, by criminal "indecency or mistreatment" offences, rather than the more direct route of a criminal theft rule. With the historic exception of criminalizing the theft of bones from Indian graves,[683] the Canadian *Criminal Code* seems to have continued this tradition through section 182(*b*).

Before the enactment of the Canadian *Criminal Code*, British courts extended the common law crime to physicians who received and possessed dead bodies known to have been illegally disinterred.[684] This view was also apparently applied in mid-nineteenth-century Canada before the Canadian *Criminal Code* was enacted. Medical professors who paid $30 to $50 for bodies obtained from local cemeteries were fined $50 for committing "offences against decency."[685] Such sales practices apparently resulted in harsher punishment in the United States as, for example, when a county undertaker was fined $750 and sentenced to eleven months in prison in 1900 for selling bodies for dissection.[686] These cases[687] and the historic legal basis of the existing mistreatment offence indicate that the sale of human remains or of a dead body may still fall under the existing criminal offence of mistreating the dead.[688] To the extent that sales of the human body or human bodily parts and tissues continue to be seen as violating basic human integrity and dignity,[689] the offence enforces the commonly shared sentiment that the dead human form is entitled to respect.

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679. Compare "W. German Universities Spark Furor over Using Remains of Nazi Victims" *The [Toronto] Globe and Mail* (12 June 1989) A12.

680. *R.* v. *Lynn* (1788), 100 E.R. 394.

681. See section I.A, above. See also A.T.H. Smith, "Stealing the Body and Its Parts" [1976] Crim. L. Rev. 622.

682. See *Lynn* , *supra*, note 680, discussing *Witchcraft Act of 1735*.

683. See *The Larceny Act*, R.S.C. 1886, c. 164, s. 98, codified in *Criminal Code*, R.S.C. 1927, c. 36, s. 385, as rep. *Criminal Code*, S.C. 1953-54, c. 51, s. 745.

684. See *R.* v. *Cundick* (1822); *R.* v. *Davies* (1828) (Lancaster assizes), described in *Select Committee*, *supra*, note 22 at 6, 7.

685. See text accompanying note 809, *infra*.

686. See *Thompson* v. *State*, 58 S.W. 213 (Tenn. 1900).

687. For more recent cases of bodily sales as a criminal offence, see *People* v. *Bullington*, 80 P. 2d 1030 (Cal. 1938) and *Commonwealth of Pennsylvania* v. *Spector* (28 October 1988), Philadelphia 87-01-2441-2445 (Court of Common Pleas). See also *infra*, note 694.

688. See *Criminal Code*, s. 182(*b*), in text accompanying note 675, *supra*.

689. See section I.C, above, and chap. 2, section IV.B, above.

An offence of "criminal mistreatment of the dead" body also expresses concern for protecting the public health and preventing nuisances. Leaving dead bodies exposed in public places, or casting them into rivers, may expose the public to disease or contaminated water, and for this reason has been regarded as improper treatment.[690] Such conduct may constitute a common nuisance by creating material annoyances and discomforts to the public. In fact, the Canadian *Criminal Code* has always classified indignities or mistreatment of corpses as nuisances.[691]

Beyond protecting the interests and sensibilities of the community, criminal rules against mistreating dead bodies promote respectful physical conduct toward the dead. As such, they protect the bodily integrity of those who are deemed worthy of respect but who cannot protect themselves. This purpose is illustrated in some American jurisdictions which criminalize mutilation or abuse of a dead body.[692] The provisions guard against the unlawful and unnecessary disfigurement, physical invasion or abuse of the dead.[693] They have recently been invoked to prosecute a physician, funeral home and hospital morgue workers for the mutilation or abuse of corpses and trafficking in human bodily parts.[694]

Finally, the offence against mistreatment of, or offering indignities to, the human body and human remains protects the next of kin's emotional and religious interests, which may stringently oppose physical invasions of the dead body.[695] Those interests may be violated by physical abuse, mutilation, sexual indecency or like conduct that would outrage ordinary family sensibilities.[696] In this sense, the criminal law protections parallel and reinforce familial interests recognized in common law and civil law.[697]

In many respects, then, the existing criminal offence of visiting indecencies or indignities on a corpse, or mistreating it, expresses abiding, fundamental values about

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690. See *R.* v. *Clark* (1883), 15 Cox C.C. 171; *State* v. *Hartzler*, 433 P. 2d 231 (N.M. 1967); *Kanavan's Case*, 1 Me. 226 (1821).

691. Compare Stephen, *supra*, note 676 at 117, 122.

692. See, *e.g.*, California Health & Safety Code, s. 7052, (West 1988 Supp.) (felony crime to mutilate corpse). See also 18 Pennsylvania Cons. Stat. Ann. 18, s. 5510 (Purdon 1990 Supp.) (criminal abuse of corpse).

693. See *Bullington*, *supra*, note 687 (removal of two gold crowns, without maiming or disfiguring body or teeth, is not felonious mutilation of corpse).

694. See *Spector*, *supra*, note 687 (physician fined $35,000 and sentenced to 16,000 hours of medical service in city prisons for 15-year practice of selling bodily parts acquired from a university hospital morgue to medical research facilities). See also *People of California* v. *Sconce* (24 May 1988), Los Angeles A573189 (Sup. Ct); "Reward Offered in Case against Mortician" *New York Times* (8 June 1989) A16 (funeral home worker receives 5 years jail for 21 criminal charges including unlawful mutilation of human remains and removal of bodily parts, for alleged sales to medical schools). See also *infra*, note 717.

695. See *Kohn*, *supra*, note 404.

696. See American Law Institute, *Model Penal Code and Commentaries: Part II* (Philadelphia, Pa.: The Institute, 1980) s. 250.10, comment 2 at 420-21 (Abuse of Corpse: "Except as authorized by law, a person who treats a corpse in a way that he knows would outrage ordinary family sensibilities commits a misdemeanor").

697. See text accompanying notes 386-395, *supra*. See generally John S. Herbrand, "Validity, Construction, and Application of Statutes Making It a Criminal Offense to Mistreat or Wrongfully Dispose of Dead Body" 81 A.L.R. 3d 1071.

death and human dignity. The offence practically functions to protect diverse affected societal interests. It commands simple respect for the dead human form, encourages respect for the sensibilities and emotional interests of family members, helps curtail public nuisances and curbs unlawful and unnecessary disfigurement, mutilation or physical abuse of the dead. Historically, the moral concern for indecency has targeted necrophilic tendencies and the sale of dead bodies.

To the extent that these concerns — historically addressed by the *Criminal Code* offence — would be more directly and clearly covered by modern statutes, modification of the existing offence may be advisable. Burial duties, public health and nuisance concerns and legal regulation of the supply of bodies for medical science are now addressed in provincial anatomy, public health and cemetery Acts.[698] Some of the sales prohibition functions arguably may also be served, or complemented, by effective statutory sales offences.[699] Yet, the role of the offence in encouraging respectful conduct, and in policing physical abuse and moral harms, remains. For if unlawful and knowing mutilation, desecration, sexual assault or general abuse of the dead body or human remains violate the physical integrity of the dead body, they also violate the dignity of the dead, violate humanity and are repugnant to fundamental moral values.

Lastly, in an examination of how and why the mistreatment offence has historically functioned as a surrogate for what might otherwise be sales and theft offences, it becomes evident that a notable ambiguity has survived the centuries. Can skeletons and anatomical specimens that are prepared from parts of dead bodies, or that were once part of the human body, technically be stolen? Leading British and Canadian analysts have been asking the question since the nineteenth century.[700] The historic basis of the offence arguably suggests that even human remains that have been lawfully procured and transformed, by dint of skill and labour, into museum mummies, human anatomical specimens or similarly processed, preserved human tissue are not protected from theft by the criminal law today; if historically they could not be subject of property, they could not be stolen.[701] Indeed, the logic of the 300-year-old common law view that one cannot steal a dead body, only

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698. See, *e.g.*, *Bodies of Deceased Persons Amendment Regulation*, Alta Reg. 298/86; *Bodies of Deceased Persons Amendment Regulation*, O.C. 82/18, A. Gaz. 1918.II.991; *Cemeteries Act*, R.S.O. 1980, c. 59. See also section III.B(1), below.

699. See section III.B, below.

700. Compare Stephen, *supra*, note 676, art. 292; G.W. Burbidge, *Digest of the Criminal Law of Canada: Founded by Permission on Sir James Fitzjames Stephen's Digest of the Criminal Law* (Toronto: Carswell, 1890) at 284, 288 (things not capable of being stolen) and Matthews, *supra*, note 385 at 219-20.

701. *Ibid.* Compare *Doodward* v. *Spence* (1907), 7 S.R. 727 (N.S.W. Austr.) (although there is no property in a corpse, skill and labour significantly modifying body may establish protectable possessory interest); J.W. Cecil Turner, ed., *Kenny's Outlines of Criminal Law*, 19th ed. (Cambridge: Cambridge University Press, 1966) at 294-95 ("It is not entirely certain whether the rule must be taken to be 'once a corpse, always a corpse'; if so the protection of the criminal law would perhaps not extend even to skeletons and similar anatomical preparations on which great labour has been expended or to ethnological collections of skulls or mummies — a conclusion which does not seem reasonable"); and J.C. Smith and Brian Hogan, *Criminal Law* (London: Butterworths, 1983) at 490-91.

its burial sheets,[702] continues to suggest, by the same token, that one cannot steal a laboratory skeleton, only the wire that binds it together,[703] nor extracorporeal bodily substances, only the vials or test tubes containing them.[704] Today, this would seem contrary to common sense, the basic values of the criminal law and broader contemporary concepts of property that now include, within criminal law protections against theft, things animate or inanimate, telecommunications services, wild animals and even electricity, all of which were not formerly within concepts of property.[705]

(3) Respecting the Newly Dead

Many of the concerns for respecting the dead, the wishes and beliefs of the family and the community sense of acceptable conduct merge into considerations on a "new class of dead patients": so-called "neomorts."[706] Modern medicine may now maintain a brain-dead individual for hours or days for transplant purposes, or for weeks or months for purposes of delivering the child of a brain-dead, pregnant woman.[707]

What is criminal mistreatment of the dead body in this context?[708] The answer is clouded partly by the ambiguous moral status of neomorts. Should they be treated as dead bodies, "dead patients"[709] or respiring, heart-beating cadavers,[710] even though they seem neither alive nor dead by conventional standards? Under what conditions, if any, is it acceptable to practice clinical instruction techniques, medical research or experimentation on the neomort? Does or should the offence against mistreatment require consent for such medical interventions? The questions are intriguing and unsettling. Moreover, they transcend the strict confines of the criminal law. The literature suggests that the answers depend largely on competing views as to the level of respect or dignity that should be accorded to the newly dead and the medical benefits of their use.

The newly dead may help advance medical science, treatment and education. A patient who has recently died from a heart attack in a hospital emergency room may afford medical

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702. See *Haynes's Case*, *supra*, note 384.

703. Skegg, *supra*, note 412 at 417-18 nn. 35, 39.

704. See *R.* v. *Welsh*, [1974] R.T.R. 478 (C.A.) (urine sample) and *R.* v. *Rothery*, [1976] R.T.R. 550 (C.A.) (blood sample).

705. See Report 31, *supra*, note 116, chap. 1(2) at 10; *Criminal Code*, s. 322.

706. See Youngner et al., *supra*, note 266 at 323.

707. See David R. Field et al., "Maternal Brain Death during Pregnancy" (1988) 260:6 JAMA 816 (brain-dead woman maintained 9 weeks at cost of $217,784 to give birth to male infant). See generally Note, "Incubating for the State: The Precarious Autonomy of Persistently Vegetative and Brain-Dead Pregnant Women" (1988) 22 Ga L. Rev. 1103.

708. See *Criminal Code*, s. 182(*b*), in text accompanying note 675, *supra*.

709. Youngner et al., *supra*, note 266 at 323.

710. Robert M. Veatch, *The Patient as Partner* (Bloomington: Indiana University Press, 1987) at 190; Field et al., *supra*, note 707 at 818-19.

students an opportunity to practice resuscitation, drug administration[711] or intubation (breathing-tube insertion) techniques.[712] Such practices are justified by arguments that they make for effective education, and that the health and safety of society are advanced by medical training on "non-persons" whose entitlement to respect in this context means "avoiding disfigurement or ridicule."[713] Similar concerns are offered to justify medical research and experimentation on cadavers ranging from blood sample collection[714] to the testing of organ transplant anesthesia, artificial respirators[715] and hearts.[716] In the public debate and criminal charges that followed experimentation on a brain-dead man hospitalized after being killed in an automobile accident in France, it was noted that medical science cannot advance without clinical research and experimentation.[717]

The benefits to medicine and to society from the use of neomorts must be weighed against competing concerns about respecting the dead and the meaning of mistreatment. In the debate following the French experimentation incident, the French national bioethics committee called for "the primacy of respect" of the person and his or her human remains; the President of France echoed those sentiments, asking society [TRANSLATION] "never to forget that the human being is not an instrument."[718] Those remarks seem to stem from a view that accords more respect to the dead because holders of that view value the symbolic dignity and humanity of the body. Moreover, they may be more apt to regard a heart-beating, respiring dead body as being more like a person than a corpse.[719]

What emerges from these competing considerations over medical benefits, potential mistreatment and respect for the dead is disagreement over the necessity for consent as a means of balancing the concerns. Minimally invasive experimentation or medical

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711. See Kenneth V. Iserson and Charles M. Culver, "Using a Cadaver to Practice and Teach" (1986) 16:3 Hast. Cent. Rep. 28.

712. See Orlowski, Kanoti and Mehlman, *supra*, note 279 and (1989) 320:6 N. Engl. J. Med. 396-97 (correspondence).

713. Orlowski, Kanoti and Mehlman, *supra*, note 279 at 440-41.

714. Barry S. Coller et al., "Inhibition of Human Platelet Function *In Vivo* with a Monoclonal Antibody: With Observations on the Newly Dead as Experimental Subjects" (1988) 109:8 Ann. Intern. Med. 635.

715. Veatch, *supra*, note 710.

716. See Susan R. Martyn, "Using the Brain Dead for Medical Research" (1986) 1 Utah L. Rev. 1 at 7 n. 37.

717. See "L'expérimentation sur les comateux" *Le Monde* (21 December 1988) 22. See also D. Dickson, "Human Experiment Roils French Medicine" (1988) 239:4846 Science 1370. Criminal assault and battery charges have apparently been brought, under s. 309 of the French Penal Code, *supra*, note 676, for [TRANSLATION] "voluntarily wounding and striking persons who, by reason of their physical or mental condition, are incapable of defending themselves"; Jean-Yves Nau, "Un texte sur les comas dépassés est à l'étude" *Le Monde* (8 March 1988) 12.

718. "L'être humain n'est pas un instrument" *Le Monde* (27 February 1988) 17. See Comité Consultatif National d'Éthique pour les Sciences de la vie et de la santé, "Avis sur l'expérimentation médicale et scientifique sur des sujets en état de mort cérébrale" (7 November 1988) in *Éthique et recherche biomédicale: rapport 1988* (Paris: La Documentation française, 1989) at 23 [hereinafter Comité]. See also Franck Nouchi, "Les expérimentations en cas de mort cérébrale autorisées sur les patients ayant fait don de leur corps à la science" *Le Monde* (8 November 1988) 32 (describing national bioethic opinion).

719. See chap. 2, sections I.C and IV, above. See also John La Puma, "Discovery and Disquiet: Research on the Brain-Dead" (1988) 109:8 Ann. Intern. Med. 606 at 607 ("The dignity and humanity of the body should never be violated, even in the pursuit of the most valuable scientific knowledge").

education techniques may not disfigure or mutilate the newly dead or otherwise violate their bodily integrity. However, even marginally invasive techniques such as intubation might be considered an indignity or mistreatment, if consent is not obtained from a family that considers such techniques offensive, outrageous or violative of religious beliefs.[720]

Should consent to such procedures be required, or should it reasonably be presumed? On the one hand, few palatable options appear to be available. Seeking consent from family members may seem awkward, inhumane and time-consuming. Moreover, these minimally invasive practices derive public health and safety benefits. All of these considerations are said to justify a policy that presumes consent to such techniques, unless there is evidence that the deceased or the next of kin object.[721]

On the other hand, other considerations mitigate in favour of a more express-consent requirement. First, by failing to ask permission a practitioner runs the risk of violating the religious and moral beliefs, or simple preference, of the next of kin. Such a practice seems inconsistent with the normal expectations of a grieving family. Even a signed general hospital consent form[722] likely fails to address what the typical, reasonable patient or next of kin would expect of, or find material to, post-mortem hospital treatment. Some, therefore, argue that presumed consent rests on an unjustified deception that may well erode doctor-patient and hospital-community trust and confidences.[723]

Secondly, non-disclosure of the practice arguably contravenes the general duty of loyalty owed by a doctor to the patient.[724] A patient gives his or her body, trust and confidences to a doctor in the belief that the doctor's medical expertise will be exercised, and interventions will be undertaken for the patient's benefit. Intervention practices that proceed without inquiry into the dead patient's or the next of kin's wishes undermine the spirit of these duties and the balance of trust. The practices reflect a unilateralism that risks denigrating or violating the legitimate interests, rights and confidences of others intimately affected. From this perspective, death does not convert the rightful possession of a patient for treatment purposes into a right to intervene on the dead patient's body for non-treatment purposes.

Thirdly, even if in some instances there are clear benefits that would justify a policy of presuming consent for use by medical science of the dead body, the benefits from medical education and research are significantly less immediate and tangible.[725] Presumed consent to organ and tissue transplantation might be legitimized, for example, because procurement has the immediate, likely and identifiable benefit of saving lives or healing.[726]

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720. Compare American Law Institute, *supra*, note 696; Orlowski, Kanoti and Mehlman, *supra*, note 279 at 441, and *Strachan*, *supra*, note 394 at 351 (hospital failure to honour family members' request to return son's body impinges familial dignity and autonomy and imposes unnecessary distress).

721. Orlowski, Kanoti and Mehlman, *supra*, note 279 at 441.

722. See Picard, *supra*, note 364 at 43.

723. See Iserson and Culver, *supra*, note 711 at 29 (Culver's commentary).

724. See text accompanying note 445, *supra*.

725. See La Puma, *supra*, note 719 at 607.

726. See *infra*, note 842.

However, the benefits from direct therapy are not morally equivalent to those from research and training.[727] The French bioethics committee so concluded in rejecting the application of the presumed-consent provisions of tissue transplant law to experimentation on neomorts.[728] The Committee recommended that such experimentation should only proceed where the individual had bequeathed, in writing, his or her body to medical science.[729]

Lastly, a presumed-consent policy of using neomorts for either medical or experimental purposes seems to counter the medical-legal ethic in Canada. While this need not prove binding, prevailing public policy often enshrines the fundamental values which so animate criminal law.[730] Anatomy and tissue donation law,[731] and medical experimentation guidelines[732] that may apply to medical interventions on neomorts,[733] generally rely on consent as the societal means for individuals or the next of kin to donate the human body to medical science. These policies are, in turn, an extension and refinement of common law principles that recognize executors and the deceased's family as proper custodians and guardians of the deceased's body.[734]

As such it appears that, absent laws that clearly authorize non-consensual interventions, the medical circumstances and benefits that would result from the use of neomorts are neither so unique nor so compelling as to justify an exception to normal consent requirements. Typically, consent means asking the family. Such a requirement seems a practical way to balance traditional criminal law and ethical concerns about respect for the dead and for familial and community interests against the evolving needs of medicine. Such a condition for use of the deceased's body may be refined in statutory[735] and institutional requirements.

Under this analysis, evidence of lawful consent to the medical intervention would raise a presumption of legality for the existing *Criminal Code* offence of mistreating the dead human body. The difficulties of a consent requirement include the time frame and the manner of asking. The delicacy of the process has been summarized in the context of experimentation on a brain-dead child:

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727. See La Puma, *supra*, note 719 at 607.

728. See Comité, *supra*, note 718.

729. *Ibid.*

730. See LRC, *Our Criminal Law*, Report 3 (Ottawa: Supply and Services Canada, 1976) at 5-9.

731. See section III.B. below.

732. See Working Paper 61, *supra*, note 295.

733. See Somerville, *supra*, note 369 at 70 (medical experimentation on cadaver may be within the "therapeutic purposes, medical education or scientific research" provisions of provincial gift tissue Acts); President's Commission, *Implementing Human Research Regulations* (Washington, D.C.: The Commission, 1983) at 39-41 (recommending research ethics board's review of cadaver experimentation).

734. See section I, above.

735. See Working Paper 61, *supra*, note 295 at 11 (federal statute on human experimentation).

> It would be essential that the experiment honor the mechanically sustained body and the parents' memory of the person who was (is, still — death is not "the end" for the parent) their child. What is likely to matter above all will be the attitude and tone of voice of the investigator seeking the parents' permission. If he bears in mind that he is a supplicant, that he is asking for something precious, and incorporates that knowledge in the asking, there is no reason not to ask. The decision is the parents'.[736]

The challenge lies in how and when to ask.

The trust, confidence and loyalty that have long been the bedrock of the provider-patient relationship thus would seem to impose special duties on medical professionals, patients and the families of patients. There may be an obligation on health care providers and hospitals to develop, refine and constantly reassess humane methods of obtaining consent in these delicate circumstances. As well, health care consumers, who will become patients, may have a moral duty to reflect on and discuss the giving of their bodies to science. These needs and delicacies strongly parallel those of the voluntary organ donation system. The use of neomorts for medical education and research would seem to be permissible "when an important social purpose is being served, when consent from a suitable guardian [*e.g.*, family member] is obtained, and when the invasion is done in a way that seeks to avoid desecration and preserves respect for the human form."[737]

III. Federal and Provincial Laws

For over a century, the federal and provincial governments have shared legal responsibilities for regulating the transfer and use of human tissue. Beyond its duties in defining relevant *Criminal Code* offences, the federal government is charged with ensuring the safety and efficacy of tissue replacement technology through the *Food and Drugs Act*. Other statutes, for example, the *Quarantine Act*, *Customs Tariff*, *Immigration Act*, *Income Tax Act* and *Canada Health Act*, impose on the federal government, on behalf of all Canadians, diverse roles and public responsibilities that bear on national tissue transfer issues. At the provincial level, anatomy, corneal and gift tissue Acts have largely defined the rules in Canada for the tissue donation process.

A. Federal Tissue Transfer Laws

(1) Drug and Medical Device Law

The *Food and Drugs Act*[738] (FDA) aims at ensuring the safety and efficacy of drugs

736. Veatch, *supra*, note 710 at 192, quoting R.A. Carson, J.L. Frias and R.J. Melker, "Research with Brain-Dead Children" (1981) 3:1 IRB: Rev. Human Subjects Res. 5.

737. Norman Fost, "Research on the Brain Dead" (1980) 96:1 J. Pediatr. 54 at 56. Accord Iserson and Culver, *supra*, note 711 at 29 (Culver's commentary); Collet et al., *supra*, note 714 at 638; Comité, *supra*, note 718; Veatch, *supra*, note 710 at 190. But see Orlowski, Kanoti and Mehlman, *supra*, note 279 at 441 and Iserson and Culver, *supra*, note 711 (Iserson's commentary).

738. R.S.C. 1985, c. F-27 [hereinafter FDA].

or devices intended for medical use by the consuming Canadian public. Administered by Health and Welfare Canada, the Act is based on the federal criminal law power.[739] Its historic purpose and functions have been to prohibit or regulate the manufacture or sale of adulterated or misbranded food, drugs, medical devices and like products potentially "injurious to health" and safety.[740] Cosmetics and medical devices have been regulated by the Act since 1939.[741] That such devices and drugs are designed, represented and intended for therapeutic, often internal, use in the treatment of illness and injury would seem to indicate a more compelling need for strict controls than is the case with cosmetics:

> It is obvious . . . that as the potential health hazard, both as regards constituents, as well as representations to the public as provided by drugs is greater, the control which must be exercised in the interest of the consuming public is necessarily more complete and strict, than would be necessary in the case of foods or cosmetics.[742]

In practical terms, the FDA sets out minimum uniform, national standards for tissue, mechanical and synthetic tissue replacement technologies. Older tissue replacement technologies — for example, blood products — are subject to the historic FDA authority to regulate biologics. "Biologics" refers to a special category of drug products, such as the polio vaccines or anti-hemophilia factors, that are derived from human and animal tissue.[743] Thus, Health and Welfare Canada's Bureau of Biologics administers FDA regulations that outline requirements for donor consent and screening, frequency of donation and the processing, labelling, licensure and sales of blood products in Canada.[744] Indeed, for decades the FDA has required that placenta used for therapeutic purposes be contaminant-free.[745] Such requirements have helped ensure the safety of albumin, a blood derivative historically processed from placenta and used in the treatment of shock, burns and hemorrhages.[746] The safety and efficacy of newer biologics technologies, such as

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739. See *R.* v. *Wetmore*, [1983] 2 S.C.R. 284 (upholding FDA deceptive drug labelling offence as criminal law power).

740. See Robert Emmett Curran, *Canada's Food and Drug Laws* (New York: Commerce Clearing House, 1953) at 137, 146 (discussing the *Adulteration Act* of 1884).

741. See *Food and Drugs Act Amendments*, R.S.C. 1939, c. 3, discussed by Curran, *supra*, note 740 at 180, 289. See also current FDA, *supra*, note 738, ss 16, 17.

742. Curran, *supra*, note 740 at 1071.

743. See Regulations under the *Food and Drugs Act*, P.C. 1942-9056, C. Gaz. 1942.I.2151 at 2172 [hereinafter P.C. 9056].

744. See HWC, *Departmental Consolidation of the Food and Drugs Act and of the Food and Drug Regulations* (with amendments to December 1990) (Ottawa: HWC, 1981) [hereinafter FDA regs], s. C.04.400 *et seq.* (plasmapheresis donation regulations). See also *Food and Drugs Act — Amendment* (Schedule No. 671), C. Gaz. 1988.I.3660 (proposing to include whole blood in existing blood derivative regulations). See generally Sanda Rodgers, "The Canadian Blood Delivery System: Liability for Blood Related Injuries" (1989) 21 Ottawa L. Rev. 311 at 322; D.W. Boucher and J. Furesz, "Regulatory Control of Blood Products in Canada" (1987) 67 Dev. Biol. Stand. 221.

745. "A manufacturer shall obtain human placenta and cord used in the manufacture of preparations from human sources only from women confined in public hospitals, and the donor of such placenta and cord shall been free from the toxemias of pregnancy, and the placenta and cord shall not show gross evidence of any pathological condition." FDA regs, *supra*, note 744, s. C.04.234. The regulation at least dates from the early 1940s. See P.C. 9056, *supra*, note 743 at 2179.

746. Hagen, *supra*, note 38 at 93. The Institut Mérieux of France, which recently purchased Connaught Laboratories of Toronto, specializes in placental blood derivatives. Canadian albumin today is derived from fractioned plasma.

genetically engineered human growth hormone and insulin, are also ensured by having them meet the regulatory standards for new drugs. Other new transplant technologies — like donated, excised organs — may be indirectly regulated, when the solutions in which they are preserved contain articles or drugs subject to FDA regulations.

The FDA also imposes health and safety responsibilities for medical device tissue replacement technology through Health and Welfare Canada's Bureau of Medical Devices.[747] The artificial kidney and heart machines are perhaps the most familiar examples of such technology.[748] For instance, the recent Health and Welfare Canada decision to continue to authorize the use of the American-made Jarvick-7 artificial heart — after the Government of the United States suspended its use for reasons of manufacturing quality control — directly affects research, clinical practices and patients at Canadian hospitals using the device.[749] The *Medical Devices Regulations* now also cover "implants." These are devices intended for implantation in the human body for thirty days or more,[750] such as cardiac pacemakers, implantable infusion pumps, nylon sutures, silicone breast implants and synthetic blood vessels. To be allowed to sell an implant in Canada, a company must generally provide substantial evidence that the implant may be produced with adequate quality and performance controls, is effective, poses no undue risk when used as intended and has proper labelling.[751] In recent years, Health and Welfare Canada has partially relied on its implant safety duties to oversee the recall by manufacturers of defective mechanical heart valves and processed brain tissue implant material.[752]

When and whether the FDA directly applies to other tissue replacement technology is less clear. Does treated, preserved or frozen bone marrow, tissue, human heart valves or semen fall within the statutory definitions and scope of the FDA so as to be subject to its requirements? Are those substances and tissues "drugs" or "medical device implants" to the extent that they are represented, sold or manufactured for use in treating disease or disorders or in correcting bodily or organic functions?[753] The answer seems to

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747. See FDA, *supra*, note 738, ss 19-21. See also *Medical Devices Regulations*, C.R.C., c. 871 [hereinafter Devices].

748. See chap. 1, section II.C, above.

749. See Christie McLaren, "Canada Allows Jarvik Heart after U.S. Ban" *The [Toronto] Globe and Mail* (12 January 1990) A8.

750. See *Medical Devices Regulations*, amendment, SOR/82-914 (amending Part V of Devices, *supra*, note 747).

751. See Devices, *supra*, note 747, ss 33-41.

752. See *ibid.*, s. 29. See also page 161 below.

753. Section 2 of the FDA, *supra*, note 738, defines drugs:

> "drug" includes any substance or mixture of substances manufactured, sold or represented for use in
>
> (*a*) the diagnosis, treatment, mitigation or prevention of a disease, disorder, abnormal physical state, or the symptoms thereof, in man or animal,
>
> (*b*) restoring, correcting or modifying organic functions in man or animal, . . .;

Section 2 also defines medical device:

> "device" means any article, instrument, apparatus or contrivance . . . manufactured, sold or represented for use in

depend on the use of the particular tissue or substance and on the interpretations given the Act.

On the one hand, one may argue that the language, structure and intent of the Act indicate that such tissues or substances fall within the scope of the Act. They all treat or mitigate diseased, disordered or non-functional human tissues; the Act does not require curative use. Some of the tissues, such as blood products and sperm, are sold in the normal sense of the term. Almost all are sold under the FDA meaning of "sell," which requires that the object be available for exchange, distribution or sale, regardless of whether the transfer involves money or value.[754] Increasing types of human tissues gain broad, safe and effective use in the treatment of bodily disorders, as a result of extensive processing, preservation and preparation through multi-step derivation processes that, in essence, yield "manufactured" therapeutic agents not unlike more conventionally manufactured therapeutic agents. The classic example is anti-hemophiliac factors manufactured by the international plasmapheresis industry. The living contact lens — which results from sculpting procured, processed and preserved human eye tissue to the individual patient's specification before implantation — is a lesser known example.[755] Under this view, then, the broad remedial purposes of the Act — to protect the public health — and the suggestive, as opposed to exhaustive, definitional language, combine to indicate that Parliament intended the definitions and reach of the *Act* to be interpreted broadly.[756]

An opposing view imparts more restrictive meaning to the language and reach of the FDA. One may argue that tissues are distinct from conventional therapeutic agents, which directly interact with human physiology, and which are commonly recognized by the drug industry and the public as conventional drugs or medical devices. Moreover, while some of the tissues are processed, few are manufactured in the normal commercial sense of the term.[757] Such considerations have, in the past, divided American courts over whether particular tissues fall within the meaning of language that is nearly identical to that used in the FDA.[758] Table 2, below, illustrates some tissue replacement technologies that are, or may be, subject to the FDA.

(*a*) the diagnosis, treatment, mitigation or prevention of a disease, disorder or abnormal physical state . . . ,

(*b*) restoring, correcting or modifying a body function or the body structure of man . . . .

754. See *ibid.*, definition "sell."

755. See Jonathan M. Frantz, Marguerite B. McDonald and Herbert E. Kaufman, "Results of Penetrating Keratoplasty after Epikeratophakia for Keratoconus in the Nationwide Study" (1989) 96:8 Ophthalmology 1151.

756. This approach was adopted in *United States* v. *Bacto-Unidisk*, 394 U.S. 784 (1969) (antibiotic sensitivity disc subject to federal food and drug regulations).

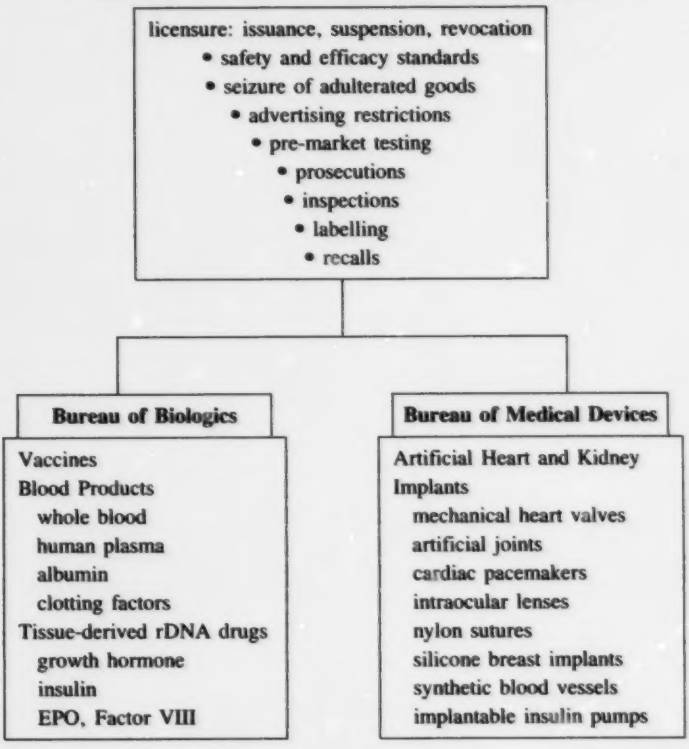
757. Although the Act does not define "manufacture," Division 2 — *Good Manufacturing Practices*, adopted under the Act, defines "produce" to mean "manufacture, prepare, preserve, package, label, test or store a drug for the purpose of sale." See FDA regs, *supra*, note 744, s. C.02.002.

758. Compare *United States* v. *Calise*, 217 F. Supp. 705 (1962) (whole blood is a drug); *United States* v. *Steinschreiber*, 219 F. Supp. 373 at 383 (1963) (human blood plasma is a drug), aff'd 326 F. 2d 759 (2d Cir.); *Blank* v. *United States*, 400 F. 2d 302 at 303-04 (5th Cir. 1968) (citrated whole blood and packed red blood cells are not drugs). Following the *Blank* case, U.S. drug law was amended. See Pub. L. No. 91-515, 84 Stat. 1297, 1308 (1970).

TABLE 2

Health and Welfare Canada:
Ensuring the Safety of Tissue Replacement Technologies

Pre- and Post-Market Controls on Drugs and Devices



Biologics? Devices? Implants?

processed, preserved, implanted bioprosthetic heart valves
• processed, implanted bioprosthetic umbilical veins
• processed, cryolathed, implanted eye lenses
• processed, preserved bone marrow
• processed, preserved semen
• processed dura mater

The biotechnological innovations of the last decades have expanded and accelerated the trend from natural to synthetic and biosynthetic tissue replacement technologies and techniques. As the processing and preservation of therapeutic human tissues proliferate, questions over whether the FDA applies to particular tissue products seem likely to become more pronounced, even as the need for minimum uniform, national standards becomes more evident. If processed and preserved heart valves,[759] bone marrow and semen[760] and processed cryolathed eye tissue are subject to the Act, then Canadian citizens in every geographic locale are protected by identical, minimum safety requirements.[761] If not, national standards depend on the consistency of pertinent provincial laws and medical professional standards and practice. From a public health and historical perspective, does the frequency and volume of interprovincial and international tissue transfers, for use as therapeutic implantable agents, make a less compelling case for protecting the consuming public than does cosmetics, which became subject to the Act fifty years ago? These considerations would seem to argue in favour of regulating preserved or processed therapeutic tissues and substances that may not strictly fall under the FDA. If construing the FDA to include such tissue unduly strains its language, function and parliamentary purpose, then perhaps the health and safety of Canadians would best be served by legislative clarification.

(2) Import-Export Laws

The FDA generally requires imported tissue replacement technology to meet the same safety and efficacy standards as do Canadian technologies.[762] Again, technologies not clearly within the scope of the FDA — such as currently imported, processed and preserved human heart valves[763] — may escape these requirements and protections. The general FDA exemption of exports from Canadian standards, as discussed below, raises basic questions about the duties owed by Canada to foreign importing nations and international consumers.[764]

FDA controls are complemented by those in the *Quarantine Act* and the *Customs Tariff*. Established pursuant to the authority of the Parliament of Canada to enact laws regarding quarantine,[765] the *Quarantine Act* empowers Health and Welfare Canada to inspect and detain imported goods reasonably suspected of being inimical to public health.[766] Thus, regulations made under the *Quarantine Act* currently provide that imported bodily parts

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759. See text accompanying note 1027, *infra*.

760. *Ibid.*

761. The FDA, *supra*, note 738, s. 30, empowers the Governor in Council to make regulations on the importation of drugs (s. 30(2)) and medical devices (s. 30(1)(*d*)).

762. See *ibid.*, s. 30(1)(*d*); Devices, *supra*, note 747, ss 14, 16-22; FDA regs, *supra*, note 744, s. G.002.008.

763. See text accompanying note 1027, *infra*.

764. See the discussion of international trade, chap. 4, below.

765. See *Constitution Act 1867*, *supra*, note 506, s. 91(11).

766. See *Quarantine Act*, R.S.C. 1985, c. Q-1, s. 5.

enter Canada on the condition that they be accompanied by a medical certificate indicating that the bodily part is free from disease.[767] Customs regulations also provide for the expedited entry into Canada of human organs.[768] Regulations made under the *Customs Tariff*[769] impose duties on imported goods and set out the tariff treatment that is to be accorded to Canada's trading partners. Under existing *Customs Tariff* Schedules, for example, while blood plasma, bones, organs and other human tissue for transplantation enter Canada duty free, hormonal extracts from human glands are subject to a duty.[770] Similarly, immigration regulations provide that medical teams accompanying brain-dead mechanically assisted cadavers or organ retrieval teams be granted expedited entry through Customs.[771]

(3) Patent Law

Federal patent law is designed to encourage public ingenuity, by generally granting to inventors an exclusive right to make, use or sell an invention for twenty years in Canada.[772] In theory, this helps to promote the development of inventions that may require years of intellectual labour and financial investment. Patent law may also help seed other inventions, by requiring patent holders to disclose into the public domain technical information on which an invention is grounded.[773]

Inventors of mechanical heart valves, new extended organ preservation solution[774] and the rDNA human growth hormone that has replaced cadaveric pituitary human growth hormone, have availed themselves of these incentives and protections, to bring therapeutic tissue replacement technologies to market. Patents have also recently been granted in the United States, and seem likely to be filed in Canada, for synthetic blood and genetically engineered hormones that help grow cartilage and bone.[775] Thus, the patent law system has helped confer health benefits on the public.

Such health benefits do not seem to come without disputes and novel questions, however. Even as Health and Welfare Canada was in the process of approving the licensure and sales of erythropoietin (EPO) — the biotech drug that stimulates red blood cell

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767. See Revenue Canada Customs and Excise, Memorandum D19-9-3, "Bodies and Body Parts for Interment in Canada" (1 June 1986).

768. Revenue Canada Customs and Excise, Memorandum R19-9-4, "Shipment of Human Organs" (1 June 1986).

769. R.S.C. 1985, c. 41 (3rd Supp.).

770. See Tariff Items 3001.90.20 and 3001.90.90, *Canada-United States Free Trade Implementation Act*, S.C. 1988, c. 65, s. 106 (Sch., Part B).

771. See *Immigration Regulations, 1978*, s. 19(1) (*j*) as am. SOR/84-849, Sch., subitem 1(1).

772. *Patent Act*, R.S.C. 1985, c. P-4, as am. R.S.C. 1985, c. 33 (3rd Supp.), ss 2, 44, 46.

773. See *Pioneer Hi-Bred*, *infra*, note 777.

774. See *supra*, note 137.

775. See Edmund L. Andrews, "Patents: Synthetic Blood" *New York Times* (21 October 1989) 34; Edmund L. Andrews, "Patents: Gains on Interleukin 3 and Formation of Bone" *New York Times* (4 November 1989) 34.

production and helps reduce blood transfusion needs for kidney dialysis and kidney transplant patients — biotechnology firms in the United States were in the court-house trying to resolve patent rights over EPO and its $300 million in annual sales.[776] While such disputes may be a conventional incident of the patent law system, other questions presented by biotechnology are novel. It may be asked whether there is something intrinsically wrong with patenting life,[777] particularly human life forms. That human cell lines have formally been patentable subject-matter in Canada since the early 1980s may suggest that it is not.[778] If not, the *Moore*[779] case nonetheless underlines a need to address the consequences of patenting some human life forms. How do we protect the bodily integrity and dignity of such human tissue sources as patients, and still provide proper incentives and protection for the creative genius of biotechnologists who cultivate potentially lucrative therapeutic fruits that benefit the public?

(4) The *Canada Health Act*

Parliament has deemed that access to high quality health care is "critical" to the continuing health and welfare of the people of Canada.[780] Accordingly, it has proclaimed "reasonable access" to health services without "financial or other barriers" to be a primary objective of Canadian health care policy.[781] The tissue transfer context suggests at least two instances in which financial and non-financial barriers might deny access.

First, tissue scarcity may erect a non-financial barrier.[782] Patients on transplant waiting lists across Canada understandably view organ scarcity as life-threatening. If national demand for blood products, corneal tissues or kidneys repeatedly outpaces available supply so that shortages become persistently acute, then scarcity imperils individual lives and national objectives. Scarcity may thus become a significant barrier to continuing

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776. *Amgen Inc.* v. *Chugai Pharmaceutical Co.*, 927 F. 2d 1200 (Fed. 1991), cert. denied, 112 S. Ct 169. See also OTA, *Recombinant Erythropoietin: Payment Options for Medicare* (Washington, D.C.: U.S. Government Printing Office, 1990). For medical discussion of EPO see chap. 1, section II.C(3), above.

777. Simple microbial life appears to be patentable subject-matter in North America. Compare *Pioneer Hi-Bred* v. *Canada (Commissioner of Patents)*, [1989] 1 S.C.R. 1623 at 1643 and *Diamond* v. *Chakrabarty*, 477 U.S. 303 (1980). See generally OTA, *New Developments in Biotechnology: Patenting Life* (Washington, D.C.: U.S. Government Printing Office, 1989); Rachel E. Fishman, "Patenting Human Beings: Do Subhuman Creatures Deserve Constitutional Protection?" (1989) 15 Am. J.L. Med. 461; Michèle Rivet, "Patenting Life-Forms and Owning Human Tissue" (Address to the Canadian Institute for the Administration of Justice, August 1990, Vancouver).

778. Compare *Application of Abitibi Co.* (1982), 62 C.P.R. (2d) 81 at 89 (Pat. App. Bd. & Pat. Commr.), *Pioneer Hi-Bred*, *supra*, note 777, and patent # 999, 546 of 9 November 1976 (human liver cell line). See also Patent Office, *Manual of Patent Office Practice* (Ottawa: Consumer and Corporate Affairs Canada, 1979), s. 12.03.02 (1/90 revision) ("inventions for new microbial life forms such as bacteria, yeasts, ... cell lines, ... may be patentable").

779. See *Moore* (1990), *supra*, note 426.

780. See Preamble to *Canada Health Act*, R.S.C. 1985, c. C-6 [hereinafter CHA].

781. *Ibid.*, s. 3.

782. See chap. 1, above, especially table 1 at page 9, and section V.

health. While some analysts may dispute whether these dynamics have attained national dimensions in Canada, they surely have inspired national law reform initiatives in foreign jurisdictions.[783] As such, legal reforms that successfully erode the scarcity barrier may save lives and advance national health policy.

Secondly, scarcity of funds may impose a barrier to access. The *Canada Health Act* (CHA), and provincial health insurance plans adopted in conformity therewith, announce a commitment to minimizing financial barriers through universal health insurance. The CHA specifically imposes a statutory duty on the provinces to provide "reasonable access" to "medically necessary" hospital and health services on a uniform basis.[784] Reasonable access is not synonymous with absolute access, however. As well, recent transplant funding litigation in the United States suggests that the term "medically necessary" is open to interpretation.[785] Still, a provincial funding choice — such as a decision to terminate funding for kidney transplants — that precludes or impedes reasonable access to transplant procedures judged medically necessary, risks subjecting the province to a loss of federal health moneys.[786]

Given these financial and scarcity concerns, it is not surprising that transplant cost data, the establishment of a national organ waiting list and the supply and demand of Canadian tissue and organ replacement technology have, in recent years, been on the agenda of federal-provincial committees that advise on administration of the CHA.[787]

(5) Health Services Laws

The Canadian government has certain responsibilities for the medical care of individuals not covered under provincial health insurance plans,[788] and for that of other specific populations in Canadian society. These groups range from active military personnel and

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783. See, *e.g.*, U.S. and Australia in chap. 4, below.

784. See CHA, *supra*, note 780, ss 12, 2, (provincial health care insurance plans "must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude . . . reasonable access to those services . . . 'insured health services' means hospital services . . . 'hospital services' means . . . services provided at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating injury, illness or disability"). For a discussion of allocating scarce resource issues in this context, see chap. 1, section IV.C, above.

785. See cases collected in note 1001, *infra*.

786. See CHA, *supra*, note 780, ss 14-17.

787. See FEDS, *supra*, note 29. See also HWC, *Canada Health Act, Annual Report* (Ottawa: HWC, for the years 1984 to 1989).

788. The CHA expressly excludes from provincial responsibility Canadian Forces members, the RCMP, federal prisoners and individuals who have not resided long enough in a province to be entitled to health services coverage. See the definition of "insured person" in the CHA, *supra*, note 780, s. 2.

the Royal Canadian Mounted Police,[789] to federal prisoners[790] and veterans,[791] to native peoples.[792] Some of these responsibilities are made explicit in federal law.

The federal *Penitentiary Act*[793] and *Criminal Code*,[794] for instance, require Correctional Services Canada to provide necessary or essential medical care to some 10,000 inmates under its charge. This statutory duty, which may be buttressed by fundamental human rights obligations,[795] encompasses such medically necessary tissue replacement technologies as the artificial kidney, blood transfusions, bone marrow and like tissue transplants.[796] Similarly, the Ministry of National Defence's medical responsibilities for some 100,000 members of the Canadian Forces has resulted in its overseeing some two dozen tissue or organ transplant procedures performed on its personnel in recent years.[797] When such tissue and organ replacement technologies are medically indicated, but unavailable at federal health facilities, the need typically will be addressed through contractual arrangements with, or medical referrals to, non-federal hospitals. Thus, military personnel in need of heart transplants are sometimes referred from the National Defence Medical Centre to the Ottawa Heart Institute.

(6) The *Income Tax Act*

The *Income Tax Act* is relevant to tissue transfers because of its potential to provide tax incentives for donation:

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789. *Ibid.*

790. *Ibid.*

791. See *Veterans Treatment Regulations*, C.R.C., c. 1585, and *Veterans Health Care Regulations*, SOR/90-594, adopted under the *Department of Veterans Affairs Act*, R.S.C. 1985, c. V-1, s. 5(1).

792. An 1876 Treaty, for example, obligates the Canadian government to provide medical services to native peoples on reserves in parts of western Canada. See *Treaty No. 6 between Her Majesty the Queen and the Plain and Wood Cree Indians and other tribes of Indians* discussed in *R.* v. *Swimmer* (1970), 17 D.L.R. (3d) 476 (Sask. C.A.). *Indian Health Regulations*, C.R.C., c. 955, have been adopted under the *Indian Act*, R.S.C. 1985, c. I-5, s. 73(1)(*g*), by virtue of the federal responsibilities outlined in s. 91(24) of the *Constitution Act 1867*, *supra*, note 506. See also the *Department of National Health and Welfare Act*, R.S.C. 1985, c. N-10 (federal health responsibilities for the people of Canada). Though the trend is towards transferring health and hospital administrative responsibilities to native peoples, HWC still runs seven native peoples' hospitals, including the only acute-care facility in the Yukon, Whitehorse General Hospital.

793. R.S.C. 1985, c. P-5, s. 37. Section 16 of the *Penitentiary Services Regulations*, C.R.C., c. 1251, mandates that "[e]very inmate shall be provided, in accordance with directives, with the essential medical and dental care that he requires."

794. Section 215(1) (*c*). See also *Attorney General of British Columbia* v. *Astaforoff* (1983), 6 C.C.C. (3d) 498 (C.A.).

795. See section IV.B, below.

796. See Correctional Service Canada, "Commissioner's Directive 800: Medical, Dental and Health Care Services" (1 January 1987), para. 26 (major surgery); Correctional Service Canada, "Commissioner's Directive 830: Prostheses and Appliances" (1 January 1987), para. 1 ("To ensure that offenders are provided with artificial devices as appropriate, which compensate for defective bodily functions").

797. National Defence Headquarters statistics indicate that 9 bone marrow, 7 cornea, 2 kidney, 1 heart/lung, 2 heart transplants, and a kidney dialysis procedure were performed on its personnel from 1984-88. Source: Department of National Defence, Office of the Surgeon General, 1990.

> Payment offered by the government might be in the form not of cash payments or credits, but through having confirmed offers as posthumous donation stand as charitable donations for taxation purposes. A taxpayer submitting a completed organ donor card might receive a receipt which, when filed with the next following annual statement of income for taxation purposes, would entitle the named recipient to an income deduction of a given amount.[798]

It is far from clear, under existing provisions of the *Income Tax Act*, whether the donation of an organ or tissue would meet the qualifications for a charitable gift or deduction.[799] The question has prompted legislative consideration in the United States.[800] While tax incentives for donation might increase the supply of scarce human tissues and organs, the economic benefits of such a policy may accrue largely to higher income taxpayers. Moreover, it could well undermine deeply held public sentiments on altruism.[801]

B. Provincial Tissue Transfer Laws

In contrast to the general focus of federal law on safety and commerce, provincial law structures the procedural framework for the donation and transfer of human bodies, organs, tissues and bodily parts. The laws result from three waves of legislation that began in the mid-nineteenth century.

(1) Anatomy Acts

The first wave of legislation started in 1849, with the enactment of a Bill designed to supply medical schools with cadavers for anatomical dissection and medical education. When the Medical Board of Montreal petitioned the Legislative Assembly of the Province of Canada, in 1843, the Board sought a legislative solution to a medical and societal dilemma, which was summarized in the Preamble to the legislation:

> WHEREAS it is impossible to acquire a proper or sufficient knowledge of Surgery or Medicine, without a minute and practical acquaintance with the structure and uses of every portion of the human economy, which require long and diligently prosecuted courses of dissections; And whereas the difficulties which now impede the acquisition of such knowledge amount almost to a prohibition of the same, and it has become necessary, in consideration of the rising importance of Medical Schools in this Province, and for the relief of suffering humanity, to make some legislative provision, by which duly authorized teachers of Anatomy or Surgery may be provided with the bodies necessary for the purpose of instructing the pupils under their charge . . . .[802]

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798. Dickens, *supra*, note 459 at 21.

799. See *Income Tax Act*, R.S.C. 1952, c. 148; S.C. 1970-71-72, c. 63, s.118.1(1) (*a*), added by S.C. 1988, c. 55, ss 77(1), 92(1) (replacing charitable donation deduction with credit). Compare *Garber*, *supra*, note 434.

800. See H.R. 540, 98th Cong., 1st Sess. (1983). See generally Note, "Tax Consequences of Transfers of Bodily Parts" (1973) 73 Colum. L. Rev. 842.

801. See Dickens, *supra*, note 459 at 21.

802. *Anatomy Act*, *supra*, note 8 (Preamble).

Proponents of the legislation described the study of anatomy as "legally impossible."[803] To receive a licence, medical students needed to have undertaken "cadaver surgery," when the supply of cadaver specimens was scarce. The scarcity prompted students to resort to body-snatching from local cemeteries, thereby running the risk of criminal punishment for desecrating human remains.[804] Those opposing the legislation suggested that it would legalize a traffic in corpses and make public property of some of the dead. They also suggested that executed criminals would be a preferred source of supply.[805]

The Legislative Assembly was persuaded by arguments that legislation would aid the healing arts in their life-saving ethic and rid communities of the nuisance of, and black markets created by, grave-robbing. The legislation adopted the principle that unclaimed bodies, publicly exposed or in such public institutions as hospitals or prisons, should be made available to medical schools.[806] The unclaimed-bodies principle derived directly from an administrative practice developed in Paris[807] in the nineteenth century, which had in turn been adopted into anatomy Acts of a decade earlier in Great Britain and Massachusetts.[808]

If the incidence of grave-robbing after 1843 is indicative of the success of the unclaimed-bodies legislation, it would seem that the Act did not prove immediately successful. As late as the 1870s, a demonstrator of anatomy at McGill University Medical School was fined for receiving dead bodies through the black market:

> Occasionally they prosecuted me for receiving the body. Now, as there is no property in a dead body and no clothes were taken, the only count on which they could summon me was, "Offence against decency," and I was usually fined $50. The judge, a Mr. Coursol, recognised the necessity of obtaining material for dissection, always fined me and nothing more was said.[809]

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803. See *Debates of the Legislative Assembly of United Canada 1841-1867: Volume III* (Montreal: Presses de l'École des hautes études commerciales, 1972) at 464 [hereinafter Debates]. See also *Journal of the Legislative Assembly of the Province of Canada*, 28 September — 9 December Session (1843) at 200.

804. See Lawrence, *supra*, note 4 at 409. See also *Lynn*, *supra*, note 680 (grave-robbing as common law criminal misdemeanour).

805. See Debates, *supra*, note 803 at 464-66.

806. "Be it therefore enacted . . . that the bodies of persons found dead publicly exposed, or who immediately before their death shall have been supported in and by any Public Institution receiving pecuniary aid from the Provincial Government, shall be delivered to persons qualified as hereinafter mentioned, unless the person so dying shall otherwise direct: provided always, that if such bodies be claimed within the usual period for interment, by *bona fide* friends or relatives, or the persons shall have otherwise directed as aforesaid before their death, they shall be delivered to them or decently interred." *Anatomy Act*, *supra*, note 8 (Preamble).

807. See Debates, *supra*, note 803 at 466. See also *Select Committee*, *supra*, note 22 at 9-10, 137.

808. *Anatomy Act* (U.K.), 2 & 3 Will. 4, c. 95; *An Act more effectively to Protect the Sepulchres of the Dead and to Legalize the Study of Anatomy in Certain Cases*, 1831 Laws of the Commonwealth of Massachusetts, c. 57. See also *Report of the Select Committee of the House of Representatives, on Legalizing the Study of Anatomy* (Boston: Dutton and Wentworth, 1831).

809. Francis J. Shepherd, *Reminiscences of Student Days and Dissecting Room* (Montreal, 1919) at 25. See also Edward Dagge Worthington, *Reminiscenses of Student Life and Practice* (Sherbrooke, Que.: Walton, 1897).

While such prosecutions may have been isolated events, the activity apparently was not. Dead bodies were even reportedly smuggled in from the United States.[810] Increases in the number of both medical schools and medical students increased the demand for anatomical subjects. In Quebec, municipalities went to extraordinary lengths to police local cemeteries from grave-snatching.[811] Non-enforcement of the Act, non-compliance by hospitals, legislative ambiguity as to the period that must elapse before a body is declared unclaimed, the absence of a clause prohibiting medical schools from receiving "black market" bodies — all purportedly contributed to undermining the workings of the legislation.[812]

Today, provincial anatomy Acts or their equivalents help supply medical schools with some 600 bodies annually for medical education and research.[813] Amendments since the nineteenth century have clarified the ambiguities and weaknesses of the initial legislation. Thus, most Acts now specify twenty-four to forty-eight hours as the waiting period after which the body becomes unclaimed.[814] With the introduction of a bequeathal principle into tissue transfer legislation, individuals are now authorized to donate their bodies to medical science.[815] In fact, the vast majority of bodies used by medical schools today are donated.

(2) Cornea Acts

A century after Canadian, British and American jurisdictions enacted laws to facilitate the medical need for anatomical studies, a second wave of legislation began. In the 1950s, medical science started to treat some forms of blindness and severely impaired vision by the surgical transplantation of eye issue from cadaver donors.[816] Since anatomy Act provisions for the donation of one's body for "anatomical examination" neither contemplated nor authorized the retention of tissue for transplantation, legislative reforms were in order.[817] Thus Great Britain enacted *The Corneal Grafting Act, 1952*, to authorize the removal of corneas from corpses, for "therapeutic purposes."[818] Five years later,

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810. See Lawrence, *supra*, note 4 at 414.

811. The following notice appeared in a Montreal paper in 1871:

> We saw to-day a tremendous weapon just finished for the watchman at the Cote des Neiges Cemetery. The gun is of enormous proportions, and will be loaded with about eight ounces of buck-shot. Parties meditating a raid on the above place of burial, will do well to recollect the formidable shooting iron now in the hands of the wide-awake watchman. A pot shot at a gang of grave desecrators would most likely supply the dissecting room with enough subjects for several weeks.

See Lawrence, *supra*, note 4 at 415, citing *Montreal Evening Star* (11 February 1871).

812. See Lawrence, *supra*, note 4.

813. See chap. 1, above.

814. See, *e.g.*, *Anatomy Act*, R.S.O. 1980, c. 21, s. 3, and *Public Health Protection Act*, R.S.Q., c. P-35, s. 57.

815. See, *e.g.*, 1971 Uniform Act, s. 4, discussed in section III.B(3), below.

816. See chap. 1, section I.B(1), above.

817. See W.A.J. Farndale, *Law on Human Transplants and Bequests of Bodies* (Beckerman: Ravenswood, 1970) at 16.

818. (U.K.) 15 & 16 Geo. 6 & 1 Eliz. 2, c. 28.

New Brunswick enacted legislation drawing largely on the British model.[819] The Canadian Conference of Commissioners on Uniform Legislation subsequently proposed a *Uniform Cornea Transplant Act*[820] which was eventually adopted by eight provinces and two territories.[821]

The *Uniform Cornea Transplant Act* both drew on and departed from the unclaimed-bodies principle. It introduced a donation principle by authorizing living donors to indicate an intention to donate one's eyes, effective after death.[822] The donation principle extended to situations where a person had made no intention to donate known, by providing that the deceased's spouse, children, parents or siblings could authorize donation.[823] A variant of the unclaimed-bodies principle took effect when family members of the deceased could not be located by permitting a person "lawfully in possession of the body" to authorize the procurement of corneal tissue.[824]

The term "lawfully in possession" was defined so as to exclude medical examiners and funeral directors.[825] Those otherwise in lawful possession of the body could be an executor of the deceased's estate or, in the absence thereof, a surviving family member. The language also meant that when an unclaimed body was in the lawful possession of a hospital, then theoretically a hospital administrator or medical physician had the authority to consent to corneal tissue procurement. In this sense, the Act introduced a narrow version of presumed consent. In those limited circumstances when an undeclared donor died in a hospital with no identifiable family who might lawfully claim the body, society presumed consent to authorize corneal donation.[826] This provision appears to have modified traditional private law rights and duties respecting the next of kin's right of possession.[827]

(3) Human Tissue Laws

The organ transplantation age generated a third wave of statutory reform. By the early 1960s, kidney transplantation had nearly a decade of experience as a therapeutic intervention

819. *Corneal Grafting Act*, S.N.B. 1957, c. 7.

820. *1959 Proceedings of the Forty-first Annual Meeting of the Conference of Commissioners on Uniformity of Legislation in Canada* (Victoria, B.C.: The Conference, 1959) at 77.

821. See J.-G. Castel, "Some Legal Aspects of Human Organ Transplantation in Canada" (1968) 46:3 Can. Bar Rev. 345 at 394.

822. *Uniform Cornea Transplant Act*, *supra*, note 820, s. 4.

823. *Ibid.*, s. 5.

824. *Ibid.*

825. *Ibid.*, s. 2.

826. It should also be noted that a provision in the Act, removing presumed-consent authority when those empowered to give consent had reason to believe the deceased would have objected (*e.g.*, on religious grounds), apparently did not extend to instances of unclaimed bodies. See *Uniform Cornea Transplant Act*, *supra*, note 820, ss 6, 2.

827. See section I, above.

for end-stage renal disease.[828] The catalyst and model for legal accommodation of organ donation and procurement again came partially from abroad. In 1961, Great Britain broadened *The Corneal Grafting Act, 1952* to include all human tissues by enactment of the *Human Tissue Act, 1961*.[829] Ontario followed suit, in 1963, by replacing its *Cornea Transplant Act* with the *Human Tissues Act*.[830] Model Uniform Canadian legislation was proposed in 1963, adopted in 1965 and revised in 1971 and 1989.[831]

Today, the major sources of provincial law governing the transfer of bodily parts and tissues are provincial versions of the 1971 Uniform *Human Tissue Gift Act*.[832] Because the 1989 revision to the Uniform Act was so recently adopted by the Uniform Law Conference and proposed to the provinces, it has yet to receive widespread legislative enactment.[833] While the 1989 Act introduces important clarifications and amendments, it continues a general commitment to consent and altruism as the uniform model of tissue donation from living and deceased donors.

For living donors, both the 1971 and 1989 Uniform Acts predicate donation on prior consent. The 1989 Act further proposes an independent assessment, by a three-person panel, of cases involving the donation of non-regenerative tissue and those involving minors donating either regenerative or non-regenerative tissue.[834] For post-mortem donation, both Acts require a pre-transplantation determination of death. The 1989 Act also makes clear that "death includes brain death as determined by generally accepted medical criteria."[835] Both generally predicate post-mortem procurement on prior consent by the deceased. For undeclared donors, consent by the deceased's "family"[836] is substituted. When the family of undeclared potential donors cannot be located, the 1989 Act authorizes coroners to consent; the 1971 Act precludes coroners or hospital administrators from such consent, but generally authorizes consent by others "lawfully in possession of the body."[837] Finally, both Acts forbid the sale of tissues, organs or bodily parts, but not blood.[838] The

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828. See chap. 1, section II.C(1), above.

829. (U.K.) 9 & 10 Eliz. 2, c. 54, repealing *The Corneal Grafting Act, 1952*, *supra*, note 818.

830. S.O. 1962-63, c. 59.

831. For a description of this process through the 1970s, see Castel, *supra*, note 821 at 397-99.

832. *1971 Proceedings of the Fifty-third Annual Meeting of the Conference of Commissioners on Uniformity of Legislation in Canada* (Jasper, Alta: The Conference, 1971) at 152 [hereinafter 1971 Uniform Act].

833. *Uniform Human Tissue Donation Act* (1989) (repealing and replacing 1971 Uniform Act, *supra*, note 832), Uniform Law Conference of Canada, *Consolidation of Uniform Acts* (Fredericton, N.B.: The Conference, 1990) at 22-1 [hereinafter 1989 Uniform Act] reprinted in appendix B, *infra* at 209-14. See also "Report of the Alberta Commissioners: Uniform Human Tissue Act" in Uniform Law Conference of Canada, *Proceedings of the Sixty-ninth Annual Meeting* (Victoria, B.C.: The Conference, 1987) at 199.

834. Compare 1989 Uniform Act, *supra*, note 833, ss 5-7, and 1971 Uniform Act, *supra*, note 832, ss 2-4. Notably, the 1989 Uniform Act eliminated the requirement of written consent.

835. Compare 1989 Uniform Act, *supra*, note 833, ss 1, 11 and 1971 Uniform Act, *supra*, note 832, s. 7.

836. Compare 1989 Uniform Act, *supra*, note 833, ss 3, 4 and 1971 Uniform Act, *supra*, note 832, ss 4, 5.

837. Compare 1989 Uniform Act, *supra*, note 833, s. 4(4) and 1971 Uniform Act, *supra*, note 832, s. 5.

838. Compare 1989 Uniform Act, *supra*, note 833, ss 15, 1 and 1971 Uniform Act, *supra*, note 832, ss 10, 1.

nine provinces and two territories that have based their tissue donation laws on the 1971 Act may be expected to study the 1989 Act for possible legislative amendment of their respective laws.[839]

In Quebec, the *Civil Code* establishes a process of tissue donation that is similar to that of the Uniform model, but with notable exceptions. Living donors may consent to donation and transplantation, if the risks assumed are not disproportionate to the expected benefits.[840] An individual may provide for the post-mortem disposition of his or her remains; in the absence of such instructions, the spouse or family of the deceased may consent.[841] The *Civil Code* provides a narrow exception to donor or familial consent, by authorizing physicians to procure organs or tissues from a recently deceased individual without consent in exigent circumstances:

> This consent is not necessary when two physicians attest in writing to the impossibility of obtaining it in due time, the urgency of the operation, and the serious hope of saving a human life.[842]

Finally, the *Code* requires that tissue transfers from living donors be done gratuitously, unless the tissue is regenerative.[843]

Taken together, the Quebec *Civil Code* and Uniform Acts represent the general model for the donation and procurement of human tissues and organs in Canada today. First, the model is generally premised on consent of the living donor or of the family of the

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839. See *Human Tissue Gift Act*, R.S.A. 1980, c. H-12; *Human Tissue Gift Act*, R.S.B.C. 1979, c. 187; *The Human Tissue Act*, S.M. 1987-88, c. 39 [hereinafter MHTA]; *Human Tissue Act*, R.S.N.B. 1973, c. H-12; *The Human Tissue Act, 1971*, S.N. 1971, No. 66; *Human Tissue Ordinance*, R.O.N.W.T. 1974, c. H-4; *Human Tissue Gift Act*, R.S.N.S. 1989, c. 215; *Human Tissue Gift Act*, R.S.O. 1980, c. 210; *Human Tissue Gift Act*, R.S.P.E.I. 1988, c. H-13; *The Human Tissue Gift Act*, R.S.S. 1978, c. H-15; *Human Tissue Gift Act*, R.S.Y.T. 1986, c. 89. See also "Report of the Alberta Commissioners", *supra*, note 833.

840. *C.C.L.C.*, art. 20.

841. *C.C.L.C.*, arts 21, 22. Art. 21 provides:

> A person of full age may, in writing, determine the nature of his funeral and the disposal of his remains. A minor capable of discernment may do likewise with the consent of his father or mother. The consent must be in writing; it may be revoked in the same way. In the absence of instructions by the deceased, usage is followed.

842. *C.C.L.C.*, art. 22:

> A physician may remove a part of the remains, if in the absence of instructions by the deceased, he obtains the consent of the consort or nearest relative of the deceased. This consent is not necessary when two physicians attest in writing to the impossibility of obtaining it in due time, the urgency of the operation, and the serious hope of saving a human life. The death of the donor must be ascertained by two physicians who do not participate in any way in the removal or in the transplantation.

843. *C.C.L.C.*, art. 20:

> A person of full age may consent in writing to disposal *inter vivos* of a part of his body or submit to an experiment provided that the risk assumed is not disproportionate to the benefit anticipated. A minor capable of discernment may do likewise with the authorization of a judge of the Superior Court and with the consent of the person having parental authority, provided that no serious risk to his health results therefrom. *The alienation must be gratuitous unless its object is a part of the body susceptible of regeneration.* The consent must be in writing; it may be revoked in the same way (emphasis added).

Compare Bill 125, *supra*, notes 380, 473.

undeclared deceased potential donor. There are exceptions. The *Civil Code* provides for non-consensual organ procurement from a deceased donor in exigent circumstances. The anatomy Acts presume consent to the procurement of dead unclaimed bodies. The 1989 Uniform Act appears to have introduced a similar provision for tissue and organ procurement from unclaimed bodies.[844] Legislative provisions in the provinces of Alberta, Manitoba, Ontario, Prince Edward Island and Nova Scotia presume consent to the removal of pituitary glands in cases involving the medical examiner or coroner in which the examining physician or coroner has no notice of objection.[845] Saskatchewan, Prince Edward Island and Manitoba have similar provisions for corneal tissue.[846] While the existing provincial presumed-consent provisions are limited to particular tissues and circumstances, they may afford models for broader legislative reforms intent on increasing the general supply of scarce tissue and organs.[847]

Secondly, the general-consent model indicates that, thus far, Canadian society has struck a balance between the interests of donors, their families and potential recipients. The statutory provisions are largely consistent with the allocation of possessory interests, rights and duties under private law. As organ or tissue scarcity becomes more critical or prominent,[848] the life-saving potential likely from increased organ availability exerts pressure on the principles of autonomy, voluntarism, bodily integrity and respect of the dead — all of which underlie the existing tissue and organ procurement system. In the two decades since the formal introduction of the existing voluntarism model, advances in medical sciences have increased the demand for organs and tissues. Heart and liver transplants have now joined kidney and corneal transplants as effective therapies. Transplant waiting lists of over 2,500 people at the end of 1989 may seem indicative of a national scarcity. If such statistics are seen as reflecting the limits of the existing system, the societal interest in the preservation of life and health argues cogently for a reconsideration or potential reform of the system. From this perspective, calls for reform translate into an opportunity to reaffirm and modify or reallocate the principles, rights and values of the current system.

Thirdly, the current Canadian system of tissue and organ procurement is based largely on the gift ethic. Organ and tissue sales are generally prohibited in Canada. However, if pure altruism is responsible for some of the existing tissue scarcity, then non-altruistic

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844. See text accompanying note 837, *supra*. This provision parallels the presumed-consent provision for medical examiner cases recently introduced into the revised anatomical gift law in the U.S. See notes 1004 and 1007, *infra*.

845. See *Fatality Inquiries Act*, R.S.A. 1980, c. F-6, s. 27; MHTA, *supra*, note 839, s. 6.1; *Coroners Act*, R.S.O. 1980, c. 93, s. 29; *Human Tissue Gift Act*, S.P.E.I., 1980, c. 27; *Fatality Inquiries Act*, R.S.N.S. 1989, c. 164, s. 20. The development of rDNA human growth hormone would seem to call into question the continuing need for such provisions. See page 17, above.

846. See Saskatchewan, *The Coroners Amendment Act, 1984*, S.S. 1983-84, c. 32; MHTA, *supra*, note 839, s. 7(2); *Cornea Transplant Act*, R.S.P.E.I. 1974, c. C-22.

847. See Margaret A. Somerville, "'Procurement' vs. 'Donation' — Access to Tissues and Organs for Transplantation: Should 'Contracting Out' Legislation Be Adopted?" (1985) 17:6 (Supp. 4) Transplant. Proc. 53.

848. See chap. 1, above.

incentives, including cash or tax benefits, might boost supplies.[849] Any such reforms of the existing system, given the values and interests implicated, would seem to be of national importance.

The existing procurement system also suffers from some practical and legal ambiguities. If the family of a recently deceased, potential donor objects to a donation of the organs, even though the donor has signed his or her donor card, whose wishes are legally required to prevail?[850] Respect for the individual's autonomy may suggest that the deceased individual's wishes ought to prevail;[851] legislative clarifications directed at eliminating this uncertainty should provide both declared donors and transplant teams with greater assurance of the authority to act on the express consent of the donor.[852] Yet, even if the declared donor's wishes are legally entitled to prevail, will not or should not continued family objections dissuade the hospital from effecting those wishes? Hospitals that seek to avoid conflict in such scenarios may decline to act on the consent despite the legal authority to do so. As such, the law has its limits.

There are ambiguities, as well, in the area of tissue sales. Does the Quebec *Civil Code* sales provision, which requires that the alienation of regenerative tissue by living donors be gratuitous, affect or apply to the sale of organs procured from the dead? Are the nullity provisions of the *Civil Code* a sufficient deterrent against organ sales, as contrasted with the penal sanctions incurred for sales under the 1971 Uniform Act? Should advertising for the purchase or offer of organs be prohibited? Both the *Civil Code* and the 1971 Uniform Act are silent on the latter question.

What is the precise legal meaning of "sales" under the Uniform Act? For example, the 1989 Uniform Act proposes to prohibit and penalize, with a fine of $100,000 or one year's imprisonment or both, tissue sales:

> No person shall buy, sell or otherwise deal in, directly or indirectly, any tissue, body or body part for the purpose of a transplant or for a therapeutic purpose, medical education or scientific research.[853]

The 1989 Uniform Act deletes the former common law definition of sales — that is, exchanges "for valuable consideration." By providing no definition, the 1989 Act appears to leave the precise legal meaning of tissue sales to court interpretation. Manitoba and many foreign jurisdictions have diverged from this approach by specifically incorporating sales definitions into their reforms.

The 1989 Uniform Act does offer clarity on the scope of the sales prohibition. The redefinition of "tissue" helps remove ambiguity over whether semen and like human

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849. See Roberts and Wolkoff, *supra*, note 492.

850. See Bill Trent, "An Old Woman, Prepared to Die: What Should the ER Doctors Do?" (1989) 141:5 C.M.A.J. 456.

851. See *supra*, notes 268, 325.

852. See 1989 Uniform Act, *supra*, note 833, s. 9.

853. *Ibid.*, s. 15(1).

reproductive substances are subject to the Act as "tissue."[854] By expressly excluding them, the 1989 Act invites legislators either to address directly human reproductive tissue sales or to allow common law principles to govern.[855] The new definition of "tissue" would also appear to remove ambiguities over whether the Act prohibits regenerative tissue sales,[856] because the 1989 Uniform Act prohibits all tissue or bodily parts sales, save blood, gametes or human concepti.[857]

Even these clarifications, however, may not prevent modern developments from provoking questions on the meaning and scope of the tissue sales prohibition. That a jurisdiction in the United States has opted to exempt cell lines from its prohibition raises a parallel query — whether the Uniform Act tissues sales ban is intended to apply to cellular or sub-cellular entities.[858] Moreover, since both the 1971 and the 1989 Uniform Acts prohibit sales only for "therapeutic purposes, medical education or scientific research," do they proscribe sales for more strictly commercial purposes such as cosmetics?[859] Some jurisdictions have adopted broader language by prohibiting tissue sales "for any purposes."[860]

(4) Provincial Tissue Law Reform

Recent legislative initiatives have been undertaken to address some of these questions and shortcomings. Beyond the 1989 revision to the Uniform Act,[861] reforms have been undertaken by such jurisdictions as Ontario, Manitoba and Quebec.[861a] Ontario and Manitoba, for example, have pursued legislative and regulatory initiatives that parallel organ donation law reform in the United States. In 1990, Ontario began requiring hospitals to adopt "procedures to encourage the donation of organs and tissues," including

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854. See 1971 Uniform Act, *supra*, note 832, s. 1.

855. See 1989 Uniform Act, *supra*, note 833, s. 1.

856. Relevant provisions of the 1971 Uniform Act sales prohibition are excerpted in appendix B, *infra* at 207. Under one view, the s. 10 sales prohibition applies only to non-regenerative tissue, because the s. 1 definition of "tissue" includes organs but excludes "tissue that is replaceable by natural processes of repair." As such, one may argue that skin, bone marrow, bone and like regenerative tissues are not covered by the prohibition. Under another view, the specific language of s. 10 controls, to prohibit both regenerative and non-regenerative tissue. Arguably, the language "any tissue for a transplant" refers to both regenerative and non-regenerative tissues, and is not qualified by the definition of tissue. Had the intention been to exclude all regenerative tissue, the provision would not explicitly and redundantly exclude blood. The exclusion phrase "other than blood or a blood constituent" may be seen to rely on language and structure apparently indicative of broad intent. 1971 Uniform Act, *supra*, note 832.

857. 1989 Uniform Act, *supra*, note 833, ss 1, 15.

858. Compare Minn. Stat. Ann. s. 145.422 (West 1988 Supp.) and 1989 Uniform Act, *supra*, note 833, ss 15, 1.

859. See 1971 Uniform Act, *supra*, note 832, s. 10; 1989 Uniform Act, *supra*, note 833, s. 12; and Dickens, *supra*, note 414 at 166.

860. See discussion of Manitoba law reforms, section III.B(4), below.

861. See 1989 Uniform Act, *supra*, note 833.

861a. Nova Scotia amended its *Human Tissue Gift Act* while this document was in preparation for publication. See S.N.S. 1991, c. 13.

(1) hospital protocols "to identify potential donors," and (2) protocols "to make potential donors and their families aware of the options of organ and tissue donations."[862]

In 1987, Manitoba amended its *The Human Tissue Act*, following a report by the Manitoba Law Reform Commission.[863] A key recommendation of the Commission concerns adoption of the encouraged-voluntarism principle and rejection of organ sales. Basing its recommendation on evidence that 72 per cent of all relatives of deceased potential donors agree to donate when approached, the Commission recommended that hospitals consider adopting procedures to ensure that those relatives are routinely sought out and given an opportunity to donate.[864] The Commission recommended this approach, in part, because such a practice appeared less likely to violate the emotional and religious interests of the potential donor's family than, for example, a presumed-consent model.[865]

Secondly, reaffirming the prohibition on the sale of human bodies and tissues, the Manitoba Law Reform Commission recommended that the definition of "sales" recognize the distinction between prohibiting the exchange of human tissue and prohibiting the payment of reasonable associated expenses.[866] Indeed, even if society deems profiting from the exchange of human bodily parts and substances abhorrent, a flat prohibition on "exchanges for valuable consideration" risks undermining organ donations that involve numerous associated expenses for travel, procurement and preservation.[867] A definition of "sales" that distinguishes between "valuable consideration" and reasonable acceptable expenses may have a less chilling effect on transfers that involve associated expenses. The legislation, adopted on the basis of the report, therefore, excludes from the definition of "selling or buying" payments of reasonable associated expenses.[868] The legislation prohibits tissue sales "for any purposes."[869]

Amendments to some of the organ transplant provisions of the *Civil Code* of Quebec have been proposed.[870]

IV. Constitutional Human Rights Law

The coming into force, in 1982, of the *Canadian Charter of Rights and Freedoms*[871]

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862. Regulation to amend Ontario Regulation 518/88 made under the *Public Hospitals Act*, O. Reg. 34/90.

863. See MHTA, *supra*, note 839. See also MLRC, *supra*, note 491.

864. See MLRC, *supra*, note 491 at 28, 54-57.

865. See *ibid.* at 35, discussing constitutional challenges of presumed-consent legislation.

866. See MLRC, *supra*, note 491 at 111-12.

867. See section I.C, "Bodily Sales," above.

868. MHTA, *supra*, note 839, s. 15(2), (3), (4).

869. *Ibid.*, s. 15(2).

870. See Bill 125, *supra*, note 380.

871. Part I of the *Constitution Act, 1982*, being Schedule B of the *Canada Act 1982* (U.K.), 1982, c. 11 [hereinafter *Charter*].

obliges government-related tissue procurement initiatives to meet a new requirement: they must be consistent with constitutionally protected human rights and fundamental freedoms.

Of course, the novelty of the *Charter* means that its influence on many aspects of Canadian society is just beginning to be appreciated. Tissue transfer law and policy issues are no exception. They provoke challenging human rights questions. Does liberty or privacy encompass a constitutionally protected right of the next of kin to be free from state-occasioned mutilation of the body of a deceased relative?[872] Does liberty include a constitutional right to sell bodily substances?[873] Does a prohibition on advertising related to organ sales infringe rights of free speech?[874] Does the body of a recently deceased person, who may be a potential donor, enjoy *Charter* protections? Or, do constitutional rights end upon death?

Settled answers to many such questions must await the developing *Charter* jurisprudence. While some recent cases have implicated tissue replacement technologies,[875] none has directly presented the constitutional aspects of organ transplantation in Canada. Nor do any cases appear to have done so under analogous provisions of the European *Convention for the Protection of Human Rights and Fundamental Freedoms*.[876] Nevertheless, some of the basic *Charter* principles may be explored to understand their relevance to tissue procurement and transfer laws. Moreover, initiatives to deal with tissue and organ scarcity in the United States have provoked a number of cases in recent years involving presumed-consent statutes. By drawing on such cases, the *Charter* principles may be given a context. Not surprisingly, the analysis reveals recurrent tension between the principles of religious freedom, privacy, bodily integrity and fair treatment of the individual, on the one hand, and the governmental or societal interests in preserving life and protecting the public health, on the other.

A. Government Initiatives

The *Charter* generally applies to government action[877] — that is, it binds both federal and provincial legislative, executive and administrative activities.[878] Thus, organ donation

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872. See *Arnaud* v. *Odom*, 870 F. 2d 304 (5th Cir. 1989) (medical examiner's unauthorized head-drop experiments on infant bodies do not violate constitutional interests of parents). Compare *Kirker*, *supra*, note 403.

873. See Karen L. Johnson, "The Sale of Human Organs: Implicating a Privacy Right" (1987) 21 Val. U.L. Rev. 741. In this respect, it should be noted that some jurisdictions would limit applicable sales prohibitions to post-mortem sales. See, *e.g.*, UAGA, *infra*, note 1004, s. 10.

874. See *Rocket* v. *Royal College of Dental Surgeons of Ontario*, [1990] 2 S.C.R. 232.

875. See, *e.g.*, *Dyment*, *supra*, note 424 and *Re L.D.K.* v. *Children's Aid Society of Metropolitan Toronto*, *infra*, note 883.

876. For a discussion of the European Convention, see *infra*, note 964.

877. *Charter* s. 32(1) provides that:

> 32. (1) This Charter applies
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> (*a*) to the Parliament and government of Canada in respect of all matters within the authority of Parliament including all matters relating to the Yukon Territory and Northwest Territories; and
>
> (*b*) to the legislature and government of each province in respect of all matters within the authority of the legislature of each province.

878. See *RWDSU* v. *Dolphin Delivery Ltd.*, [1986] 2 S.C.R. 573.

legislation must conform to the *Charter*, as must the tissue-procurement activities of provincial coroners and medical examiners. While a recent Supreme Court decision indicates that the internal policies of Canadian hospitals may generally not be subject to the *Charter*, hospital practices must nonetheless conform to provincial human rights law.[879] As such, hospital organ-procurement policies and initiatives are still required to meet the basic commands of human rights.

B. Bodily Integrity and Privacy

The *Charter* protects bodily integrity and privacy through its protections of "life, liberty and security of the person,"[880] and its prohibition against "unreasonable search or seizure"[881] and "cruel and unusual treatment."[882] For example, the non-consensual administration of a blood transfusion has been deemed violative of a twelve-year-old child's bodily integrity and the security of his person.[883] In the criminal law context, the Supreme Court of Canada has applied the search and seizure provision of the *Charter*, and found that the non-consensual taking of a blood sample from an unconscious patient violated personal privacy and human dignity.[884] The court has construed the right to security of the person to include protection of one's physical and mental integrity.[885] Other Canadian courts have declared that for the state to incarcerate an individual, and then deny him or her meaningful access to essential health services, constitutes cruel and unusual treatment or contravenes the fundamental right to security of the person.[886] These principles may encompass medically necessary tissue replacement technology.[887]

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879. See *Stoffman* v. *Vancouver General Hospital*, [1990] 3 S.C.R. 483 at 533-48. See also *Peters* v. *University Hospital Board*, [1983] 5 W.W.R. 193 (Sask. C.A.) and *Human Rights Code, 1981*, S.O. 1981, c. 53, s. 1.

880. *Charter*, s. 7.

881. *Ibid.*, ss 8, 24(2).

882. *Ibid.* s. 12.

883. *Re L.D.K.* v. *Children's Aid Society of Metropolitan Toronto* (1986), 48 R.F.L. (2d) 164 (Ont. Fam. Ct).

884. See *Dyment*, *supra*, note 424 and accompanying text.

885. See *R.* v. *Morgentaler*, [1988] 1 S.C.R. 30 at 53.

886. See *R.* v. *Downey* (1990), 42 C.R.R. 286 (Ont. Dist. Ct) (holding deprivation of essential medical treatment from a prisoner with AIDS to be cruel and unusual treatment); *McNamara* v. *Caros*, [1978] 1 F.C. 451 (T.D.); *Collin* v. *Lussier*, [1983] 1 F.C. 218 at 237 (T.D.) (prisoner's right to security of person includes protection of bodily integrity and right to medical care and other necessities of life), partially rev'd on other grounds [1985] 1 F.C. 124 (A.D.). Federal prisoners also have a statutory right to "essential medical . . . care." See *Penitentiary Services Regulations*, *supra*, note 793, s. 16. The U.S. constitutional analogue of security of the person, the due process clause, entitles pre-trial unconvicted detainees to necessary medical care. See *City of Revere* v. *Massachusetts General Hospital*, 463 U.S. 239 (1983). See also *Thompson* v. *City of Portland*, 620 F. Supp. 482 (D.C. Me. 1985). For convicted, incarcerated individuals in the U.S., "deliberate indifference to a prisoner's serious medical needs" constitutes "cruel and unusual punishment." *Estelle* v. *Gamble*, 429 U.S. 97 at 103-104 (1976) ("An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical 'torture or a lingering death,' . . . In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose. . . . The infliction of such unnecessary suffering is inconsistent with contemporary standards of decency"). For general commentary on prisoners' *Charter* rights see A. Wayne MacKay, "Inmates' Rights: Lost in the Maze of Prison Bureaucracy?" (1987-88) 11 Dalhousie L.J. 698.

887. *Thompson* v. *City of Portland*, *supra*, note 886 (failure to provide necessary medical care to former transplant recipient in police custody contravenes the constitutional protection of due process).

As such, the right to security of the person applies to and protects living donors and potential recipients. Some commentators query whether it also applies to deceased donors — that is, whether the non-consensual taking of organs from a cadaver violates security of the person.[888] The concern may have particular force in considerations over the exemption of minors or mentally disabled persons from post-mortem presumed-consent laws. Such laws generally permit individuals to rebut the presumption of consent, by registering an objection. However, applying those laws to persons incapable of meaningfully registering their intentions might deny them an equal opportunity to protect the bodily integrity or security of their persons after death.[889]

Assuming that the right to security of the person applies to both living and deceased donors, where a governmental law or policy infringes that right, the infringement still may or may not be constitutionally permissible. For while the right to bodily integrity ranks high on the scale of societal values,[890] it is not absolute. It may be abridged if this is done in accordance with principles of fundamental justice, or if the right is reasonably limited by a law "demonstrably justified" by the needs of a "free and democratic society."[891] The balancing of human rights and basic democratic needs, under the Supreme Court of Canada jurisprudence, requires the government to show (1) an important legislative purpose that bears on a "pressing and substantial concern," and (2) proportionality — the means chosen to advance the government objective must relate rationally to the purpose, impair the right in question as little as possible and show proportionality between the government objective and the actual effects of the means chosen to advance that objective.[892] Those requirements are designed to give constitutional rights breathing space even when they are infringed, by stipulating that infringements be done with alternatives that are least restrictive of fundamental freedoms.[893]

Analogous principles have guided courts in the United States in examining whether presumed-consent practices and legislation violate human rights. In the few cases that have directly presented the question, the courts have upheld the constitutionality of the practice or law. Some courts have differed over whether the underlying right in question — for example, interference with the next of kin's right of possession for burial purposes — arises to a constitutional dimension.[894] Other courts have emphasized that narrowly drawn

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888. See Picard, *supra*, note 364 at 132 n. 649.

889. For a discussion of the French exclusion and Belgian inclusion of minors from presumed-consent law, see text accompanying notes 961-962, *infra*.

890. See *Ewe*, *supra*, note 362.

891. See *Charter*, ss 7, 1.

892. *R.* v. *Oakes*, [1986] 1 S.C.R. 103 at 138-39. See generally Peter W. Hogg, "Section 1 Revisited" (1990) 1 Nat'l J. Const. L. 1.

893. See Peter W. Hogg, *Constitutional Law of Canada*, 2d ed. (Toronto: Carswell, 1985) at 686-87. Laurence H. Tribe, *American Constitutional Law*, 2d ed. (Mineola, N.Y.: Foundation, 1988) at 1032, 1256, 1377.

894. See *Brotherton* v. *Cleveland*, 923 F. 2d 477 (6th Cir. 1991); *Georgia Lions Eye Bank* v. *Lavant*, 335 S.E. 2d 127 (Ga. 1985), cert. denied 475 U.S. 1084 (1986); *Tillman* v. *Detroit Receiving Hospital*, 360 N.W. 2d 275 (Mich. App. 1984). Compare, Erik S. Jaffe, "She's Got Bette Davis['s] Eyes: Assessing the Nonconsensual Removal of Cadaver Organs under the Takings and Due Process Clauses" (1990) 90 Colum. L. Rev. 528 and Donald R. McNeil, "The Constitutionality of 'Presumed Consent' for Organ Donation" (1989) 9 Hamline J. Pub. L. & Pol'y 343.

legislation reasonably advances the state interests in the promotion of health and preservation of life:

> Our review of section 732.9185 reveals certain safeguards which are apparently designed to limit cornea removal to instances in which the public's interest is greatest and the impact on the next of kin the least: corneas may be removed only if the decedent is under the jurisdiction of the medical examiner. . . .
>
> In conclusion, we hold that section 732.9185 is constitutional because it rationally promotes the permissible state objective of restoring sight to the blind. In so holding, we note that laws regarding the removal of human tissues for transplantation implicate moral, ethical, theological, philosophical, and economic concerns which do not readily lend themselves to analysis within a traditional legal framework.[895]

C. Freedom of Conscience and Religion

Adopting narrow, proportionate means to advance legitimate government and societal interests may prove equally important in governmental tissue procurement and transfer initiatives that burden religious beliefs. The *Charter*[896] protects the exercise of religion as a fundamental freedom:

> Freedom must surely be founded in respect for the inherent dignity and the inviolable rights of the human person. The essence of the concept of freedom of religion is the right to entertain such religious beliefs as a person chooses, the right to declare religious beliefs openly and without fear of hindrance or reprisal, and the right to manifest religious belief by worship and practice or by teaching and dissemination.[897]

Thus, the compelled transfusion of blood into Jehovah's Witnesses, whose religious dictates do not permit them to receive transfusions, may burden their religious beliefs.[898] Orthodox Judaism forbids post-mortem dissection and like invasions of the body.[899] The tenets of other believers, for example, adherents to some Far Eastern religions, strictly forbid any mutilation of the body after death, including organ procurement or autopsy.[900]

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895. *State* v. *Powell*, 497 So. 2d 1188 at 1191, 1193-94 (Fla. 1986), cert. denied 481 U.S. 1059 (1987).

896. Section 2(*a*).

897. *R.* v. *Big M Drug Mart Ltd.*, [1985] 1 S.C.R. 295 at 336.

898. See *L.D.K.*, *supra*, note 883. See also *Malette*, *supra*, note 363. For a recent U.S. case, see *Public Health Trust of Dade County* v. *Wons*, 541 So. 2d 96 at 102 (Fla. 1989) ("Mrs. Wons did not, and does not, wish to die should her condition recur. However, because of her strong religious beliefs, she has chosen to face death rather than to accept a blood transfusion. . . . As a parent, however, she also must consider the example she sets for her children, how to teach them to follow what she believes is God's law if she herself does not. The choice for her cannot be an easy one, but it is hers to make. It is not for this Court to judge the reasonableness or validity of her beliefs. Absent a truly compelling state interest to the contrary, the law must protect her right to make that choice.").

899. *Atkins* v. *Medical Examiner*, 418 N.Y.S. 2d 839 (1979); *Kohn*, *supra*, note 404. See also D.W. Weiss, "Organ Transplantation, Medical Ethics, and Jewish Law" (1988) 20:1 (Supp. 1) Transplant. Proc. 1071.

900. See *You Vang Yang* v. *Sturner*, 728 F. Supp. 845 at 846 (D.R.I. 1990) (autopsy law and Hmong religious practices) withdrawn, 750 F. Supp. 558.

Still others' religions, such as those of some native peoples, orthodox Islam and Shintoism, may proscribe either post-mortem organ procurement or the receipt of cadaveric tissue.[901]

These views of conscience and religion may well be held by the minority in Canadian society. Should the numbers matter, and disentitle minority adherents of conscience from a right to exercise their beliefs on the integrity of the dead human body as a necessity for ensuring passage to an afterlife?[902] To the contrary, part of the purpose of the *Charter* guarantee is to entitle all individuals — be they in the minority or in the majority — to freedom of conscience and religion.[903] Indeed, to protect against coercion and to provide meaningful equality of religious autonomy, more protection may be warranted for those holding unfamiliar, non-majoritarian religious views.[904] Such concerns appear to have prompted the Alberta Office of the Chief Medical Examiner to exclude Hindus, Christian Scientists, orthodox Jews, Moslems, native Canadian Indians, Metis and Inuit peoples from its five-year-old practice of routinely consulting the families of deceased individuals, under its jurisdiction, to inquire whether they wish to donate tissue.[905] The exemption would seem responsive to *Charter* duties to accommodate and to minimize the impairment of the free exercise of religion.[906]

This is not to say that religious freedom in a pluralistic, democratic society is absolute and cannot be restricted:

> Freedom in a broad sense embraces both the absence of coercion and constraint, and the right to manifest beliefs and practices. Freedom means that, subject to such limitations as are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others, no one is to be forced to act in any way contrary to his beliefs or conscience.[907]

Thus, a compelling societal interest in determining the cause of unusual deaths, for the administration of criminal justice or to safeguard public health, may justify the performance of a forensic autopsy, despite the religious beliefs of the decedent or surviving family.[908] State interests in the preservation of life and protection of health, particularly

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901. See *Begay* v. *State*, 723 P. 2d 252 (N.M. App. 1985) (autopsy law violates native American religious beliefs). Orthodox Muslims construe the Koran, traditionally regarded as the literal word of God and a major source of Islamic law, as proscribing the procurement or receipt of cadaveric organs. See Iyer, *supra*, note 319; Claude Jacquinot, "Sur les Prélèvements d'organes" Gaz. Pal. 1979. 1er. sem. Doctr. 57.

902. See John Dwight Ingram, "State Interference with Religiously Motivated Decisions on Medical Treatment" (1988) 93 Dick. L. Rev. 41 at 65 ("The very essence of most religious beliefs is the relationship of a person to a supreme being and the determination of the relative value of one's physical life on earth and a potential spiritual life hereafter").

903. *Big M Drug Mart Ltd.*, *supra*, note 897 at 337.

904. See *ibid.* See also Note, "Burdens on the Free Exercise of Religion: A Subjective Alternative" (1988-89) 102 Harv. L. Rev. 1258 at 1277.

905. See Alberta Attorney General, Office of the Chief Medical Examiner, *Protocol for Making Request for Donation of Tissue* (April 1987).

906. See *Oakes*, *supra*, note 892 at 136 and Hogg, *supra*, note 893 at 712.

907. *R.* v. *Edwards Books and Art Ltd.*, [1986] 2 S.C.R. 713 at 758, citing *Big M Drug Mart Ltd.*, *supra*, note 897.

908. See *Snyder* v. *Holy Cross Hospital*, 352 A. 2d 334 (Md. App. 1976). But see *Atkins*, *supra*, note 899 and *You Vang Yang*, *supra*, note 900. Following *Snyder*, relevant Maryland law was amended to be more accommodating of religious objections. See William J. Curran, "Religious Objection to a Medicolegal Autopsy: Case and a Statute" (1977) 297:5 N. Engl. J. Med. 260. Compare *Époux Camara*, *infra*, note 950.

of those who cannot protect themselves, have motivated the prosecution and conviction of Christian Scientists for failing to provide dependent minors with customary, life-saving medical treatment.[909] These interests have also persuaded courts to uphold the authority of the state to administer life-saving blood transfusions to infants, over parental religious objections.[910]

In essence, then, the *Charter* seeks to strike a dynamic balance to give effect to the principle of religious freedom. When societal interests of paramount importance are at issue that cannot be advanced by other viable alternatives, the government-chosen objective and means may necessitate infringing or overriding individual religious practices. Otherwise, the societal valuing of religious freedom as a fundamental human right bespeaks a duty to accommodate individual beliefs and acts of conscience. A particular instance of societal balancing may depend, delicately, on the degree and effects of religious infringement, and on the strength of the government objective, means of achieving its objectives and its accommodation of the religious beliefs. Hence, in the United States constitutional transplant and autopsy jurisprudence, the degree to which state legislation burdens and accommodates the exercise of religion has proved important. When a woman contended that her religious beliefs were violated by a medical examiner's retention of her husband's organs following an autopsy, the court upheld the law by finding it accommodated religious beliefs in providing the family with an opportunity to object in advance to any such retention.[911] More recently, a court initially found that state autopsy law violated religious beliefs, in part, because it failed to adopt less burdensome alternatives for achieving the government goal.[912]

D. Non-discrimination and Equality

The constitutional requirement of equality protects against government discrimination by mandating the equal benefits and burdens of the law:

> Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.[913]

A complainant alleging discrimination must show unequal treatment, or the effects and discriminatory impact of a government initiative, based on one of the above-enumerated

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909. See *R.* v. *Lewis* (1903), 7 C.C.C. 261 (Ont. C.A.) (affirming manslaughter conviction for Christian Scientist's failure to provide medical necessities for son who died of diphtheria). See also *Tutton*, *supra*, note 529.

910. *Re McTavish and Director, Child Welfare Act* (1986), 32 D.L.R. (4th) 394 (Alta Q.B.). But see *B.(R.)* v. *Children's Aid Society of Metropolitan Toronto* (1988), 47 D.L.R. (4th) 388 (Ont. C.A.).

911. *Fuller* v. *Marx*, 724 F. 2d 717 (8th Cir. 1984).

912. *You Vang Yang*, *supra*, note 900 at 857.

913. *Charter*, s. 15.

grounds or on one analogous thereto.[914] The Supreme Court of Canada has indicated a willingness to construe the constitutional requirement of equality broadly.[915]

The requirement imposes on government a duty to act impartially and to avoid arbitrary and unreasonable classifications of or actions against individuals. Government decisions to fund or not fund a particular transplant procedure might discriminate, if they are sufficiently arbitrary and irrational as to deny equal protection of the law.[916] If hospitals are subject to the *Charter* or statutory human rights protections, then criteria for organ transplant waiting lists must comport with basic human rights principles.[917] Thus, criteria that give priority on a basis such as ethnic or national origin, or ambiguous "medical" criteria that effectively exclude particular classes of disabled transplant recipients, must offer cogent reasoning to withstand legal scrutiny.[918] Similar equality concerns may apply to initiatives to apply a different criterion of death for anencephalic infants, to the extent that it unreasonably and disproportionately discriminates against them on the basis of physical disability. If the government interest in the preservation of life might be advanced by organ procurement initiatives less burdensome of the right to life or security of the person, the *Charter* may well require such alternatives.

Indeed, that approach should, perhaps, inform all governmental tissue transfer and procurement initiatives, including law reform options and recommendations. For if one such initiative challenges the human right to equality, and another challenges the freedom of religion or security of the person, the *Charter* would seem to oblige all to respect at least one human rights lesson: If, in the choice between competing law reform options, one emerges that is (1) least burdensome of fundamental human rights, (2) likely to prove relatively more accommodating of those rights, and (3) depends on rational, narrowly tailored means that substantially advance a pressing and substantial government objective, then that option would seem constitutionally preferred.

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914. See *Andrews* v. *Law Society of British Columbia*, [1989] 1 S.C.R. 143 at 182. See also *R.* v. *Turpin*, [1989] 1 S.C.R. 1296 at 1330-35.

915. *Ibid.*

916. See *Brillo* v. *Schaller* (13 June 1986), Arizona 233587 (Sup. Ct) (ordering state funding of adult liver transplant after holding denial thereof to be irrational and violative of equal protection). This argument was also advanced in litigation that helped persuade the state of Vermont to amend its policy of non-funding of adult liver transplants. The intended transplant recipient in the case died before she could avail herself of the funding change. See *Schmokel* v. *Secretary of State* (6 December 1988), Washington S-578-88 (Sup. Ct). See also Sally Johnson, "Vermont Case May Upset Transplant Policy" *New York Times* (15 January 1989) 34.

917. For example, transplant waiting list procedures that seem not to discriminate on the enumerated or analogous grounds of s. 15, arguably may abridge s. 7 protection of life and security of person, by denying an equal opportunity to life in a manner inconsistent with principles of fundamental justice. Compare *Stoffman*, *supra*, note 879 and *Turpin*, *supra*, note 914 at 1334-35. See also text accompanying notes 221-224, *supra*.

918. See *Brillo*, *supra*, note 916 and Note, "Patient Selection for Artificial and Transplanted Organs" (1969) 82 Harv. L. Rev. 1322 at 1338. Compare *supra*, note 221, and *infra*, note 1001.

CHAPTER FOUR

Comparative and International Law Perspectives

To the extent that reforms to tissue transfer laws in Canada may be in order, the leading approaches and recommendations of foreign jurisdictions might provide models for, or at least inform, Canadian legislative initiatives. A survey of the pronouncements of Australia, Great Britain, France, Belgium, the Council of Europe and the United States on organ procurement from deceased, potential donors generally reveals variations of the express-consent, presumed-consent and required-request models. All of the surveyed jurisdictions have struggled with defining the precise legal role that surviving family members should play in the donation process. In some, legal disputes have arisen over safety concerns and over issues involving deposited tissue and ownership. All jurisdictions have also devoted particular attention to regulating payments associated with tissue transfers and to prohibiting organ sales. In a broader sense, these national approaches to tissue procurement, safety and sales help sketch evolving legal controls over tissue transfers between nations in the international community.

I. Great Britain: Express Consent — Opting In

For over a century, the anatomy, cornea and gift tissue laws of Great Britain have exerted enormous influence on the anatomy and tissue transfer laws of Canada.[919] In Great Britain, gift tissue legislation requires evidence of either consent from the potential donor before death or the post-mortem consent of the family for the removal of organs from cadavers.[920] This express-consent approach to procuring cadaver organs has been described as "opting in."[921] In the absence of evidence that the deceased or the deceased's family has expressly consented, society does not authorize the procurement of tissues or organs from the dead body. While this approach seems consistent with common and civil law traditions respecting dead bodies,[922] it may be criticized for failing to take into account the need for advancing life-preservation principles through the law: without express consent, organs that might have been used for transplantation perish.

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919. See pages 127-35, above.

920. *Human Tissue Act, 1961*, *supra*, note 829.

921. See Somerville, *supra*, note 847.

922. See pages 66-69, above.

Indeed, in recent years, national and international organ scarcity has exerted pressure on the existing British organ donation system, prompting law reform initiatives. Some 3,500 individuals were on kidney transplant waiting lists for 1988.[923] Underlying reasons for this scarcity in Great Britain parallel those identified in North America. Studies suggest that potential donors do not become actual donors in Great Britain owing to the failure to diagnose brain death, the failure of professionals to request donation and the failure of potential donors or their families to consent to donation.[924] For such reasons, the British Department of Health has recently required hospital authorities to adopt written procedures for identifying potential donors, diagnosing brain death and facilitating the consent process for organ donation with relatives.[925] The British are also considering the merits of increased professional training and a general statutory requirement that medical professionals sensitively approach the families of recently deceased undeclared potential donors in order to provide them with an opportunity to donate on behalf of the deceased.[926] Similar required-opportunity and required-request approaches to undeclared donor circumstances have been adopted in other traditionally express-consent jurisdictions such as Canada and the United States.[927]

Recent reports about the involvement of British doctors in international organ sales have fuelled the debate over options for increasing organ donation. While the sale of human bodies for anatomical purposes was established as a criminal misdemeanour in the eighteenth century, nineteenth- and twentieth-century British transplant laws created regulatory tissue transfer regimes that were silent on penal sanctions for organ sales.[928] The silence was broken in 1989. Allegations that impoverished Turks received £2,000 to £3,000 for "donating" a kidney to needy Turkish recipients in London[929] prompted the British Parliament to enact an organ sales prohibition.[930] The *Human Organ Transplants Act 1989* provides for a maximum £2,000 fine or three months' imprisonment or both for the offer, solicitation, purchase or sale of an organ. The Act does not preclude payment for the cost of removing, transporting or preserving organs or for expenses or lost earnings reasonably and directly incurred by the organ donor.[931] As such, it parallels the recently enacted

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923. John Warden, "Kidneys Not for Sale" (1989) 298:6689 Br. Med. J. 1670.

924. Sheila M. Gore, Charles J. Hinds and Annabel J. Rutherford, "Organ Donation from Intensive Care Units in England" (1989) 299:6709 Br. Med. J. 1193. But see A. Bodenham, J.C. Berrialge and G.R. Park, "Brain Stem Death and Organ Donation" (1989) 299:6706 Br. Med. J. 1009. See also Pamela E. Buckley, "The Delicate Question of the Donor Family" (1989) 21:1 Transplant. Proc. 1411.

925. Department of Health, HC (88)63 (Provision of Donor Organs for Transplantation). See also (February 89) 47 I.M.E. Bull. 6.

926. J. Wallwork, "Organs for Transplantation" (1989) 299:6711 Br. Med. J. 1291.

927. See chap. 3 above.

928. See *ibid.*, page 109 and notes 808, 818, 829, *supra*.

929. See Brahams, *supra*, note 477; Richard Beeston, "Mother Tells of Selling Kidney" *The [London] Times* (26 January 1989) 1. Turkish law penalizes the sale of organs. See "Law No. 2238 of 29 May 1979 on the Removal, Storage, Transfer and Grafting of Organs and Tissues" *T.C. Resmi Gazete*, No. 16655 (3 June 1979), reprinted in (1980) 31:4 Int'l Dig. Health Leg. 866.

930. *Human Organ Transplants Act 1989*, *supra*, note 526.

931. *Ibid.*

tissue sales prohibition in Manitoba.[932] It also severely restricts transplants between non-genetically related individuals, on the theory that the motivation for such transplants ought to be subject to close scrutiny. The Act also prohibits advertising related to organ sales — an approach that has not been pursued in Canada to date.[933]

II. France, Belgium and the Council of Europe: Presumed Consent — Opting Out

The procurement and transplant laws of France and Belgium at once parallel and differ from those of Great Britain. All three prohibit organ sales. Indeed, in approaches that parallel both the British law and French regulations requiring human milk and blood banks to operate on a non-profit basis,[934] the French and Belgian transplant laws prohibit payments beyond reimbursement for costs.[935] Yet Belgium, France and many civil law nations[936] have not followed the express-consent approach of Great Britain to post-mortem organ procurement. The fifteen-year-old French and four-year-old Belgian laws have adopted, and thus provide insight into, the presumed-consent approach. Related French initiatives also reflect societal efforts to clarify and understand the moral and legal status of the human body today.

A. France

The French have relied on presumed consent for cadaver organ procurement since 1976. The law authorizes the post-mortem retention of one's organs or tissues for therapeutic and scientific uses unless, prior to death, one objects to such use.[937] Thus, when identifying a potential donor, a physician is required to check the hospital registry to confirm an absence of objection.[938]

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932. See MHTA, *supra*, note 839, s. 15.

933. See pages 127-36, above.

934. For French milk bank regulations, see *Loi n° 89-899 du 18 décembre 1989*, J.C.P. 1990.III.15736, and *Arrêté du 15 juillet 1987*, J.O., 4 August 1987, 8769. For French blood bank regulations, see *Codes de la santé publique, de la famille et de l'aide sociale*, 8th ed. (Paris: Dalloz, 1989) ss L-673 and L-674.

935. Compare s. 3 of *Loi n° 76-1181 du 22 décembre 1976*, J.O., 23 December 1976, 7365, reprinted in (1977) 28:2 Int'l Dig. Health Leg. 271, and *Law of 13 June 1986 on the removal and transplantation of organs* (Belgium), s. 4, reproduced in (1987) 38:3 Int'l Dig. Health Leg. 523 [hereinafter *Law of 13 June 1986*].

936. See Somerville, *supra*, note 847 at 58. See generally A. Cantaluppi, A. Scalamogna and C. Ponticelli, "Legal Aspects of Organ Procurement in Different Countries" (1984) 16:1 Transplant. Proc. 102.

937. *Loi n° 76-1181*, *supra*, note 935, s. 1.

938. See *Décret n° 78-501 du 31 mars 1978*, J.O., 4 April 1978, 1497, s. 10, as amended by *Décret n° 90-844 du 24 septembre 1990*, J.O., 25 September 1990, 11606. See also *Circulaire du 3 avril 1978*, J.O., 5 April 1978, 1530.

After more than a decade of experience, the presumed-consent approach in France appears to have had little positive impact on organ scarcity:[939]

> [T]he results of the presumed consent system in France have proven disappointing. Although the supply of organs has increased somewhat, it has been greatly exceeded by the growth of demand. In 1984 there were nearly a thousand kidney transplants performed in France, but almost three thousand people remained on the waiting list.[940]

The results may flow from certain internal tensions in the theory of presumed consent. They may also flow from difficulties in applying the presumed-consent theories to the realities of clinical practice.

Presumed-consent theory maintains that society may reasonably presume — on the basis of life-saving necessity and community altruism — that one consents to post-mortem donation, unless one objects while alive. Silence equals consent. This approach is thought to advance the life-saving interests of needy transplant recipients and to avoid tormenting the families of the recently deceased with potentially insensitive organ donation requests that may exacerbate grief.[941] The presumption of consent is not absolute, however. It may be rebutted by evidence of non-consent. Proof of one's intentions might come in the form of a formal written declaration, informal correspondence, a pattern of conduct or testimony on one's oral statements. As such, the practical question becomes, How is evidence of non-consent to be generally manifested and collected? If a registry, such as those in France, becomes the principal means of revealing the deceased's intentions, should it be the only means?

Societies that strictly limit evidence to that contained in registries likely advance procurement efficiency, by limiting the sources that medical professionals need consult before procurement. Such an approach may sometimes, however, exclude evidence that is more accurate and probative of the deceased's intentions. In contrast, societies more cautious about presuming an individual's intentions may welcome other evidence of the deceased's intentions, especially when it does not conflict with the registry. Kinship and shared experiences of life may make families apt sources of evidence. Thus, if the medical team finds no objection in the registry, should it consult the family to confirm the absence of objection by the deceased?

France has sought to resolve these tensions by encouraging medical professionals to give families the opportunity to offer evidence of the deceased's intentions:

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939. See ONT, *supra*, note 29 at 93.

940. Note, "Refining the Law of Organ Donation: Lessons from the French Law of Presumed Consent" (1987) 19 N.Y.U. J. Int'l L. & Pol. 1013 at 1024-25.

941. Conseil d'État, *Sciences de la Vie: De l'Éthique au Droit*, 2d ed. (Paris: La Documentation française, 1988) at 36. See also Jesse Dukeminier and David Sanders, "Organ Transplantation: A Proposal for Routine Salvaging of Cadaver Organs" (1968) 279:8 N. Engl. J. Med. 413 at 416.

[TRANSLATION]
Under the law, only the wishes expressed by the person before his or her death should be considered, not those of the family. However, the family is still most often the privileged depositary of these wishes, whether the deceased has confided them to relatives, or whether relatives are in possession of documents or other evidence of the deceased's refusal or consent to the procurement. Where the family is not the direct depositary of the deceased's last wishes, it is often in the best position to know or discover the deceased's motivations and communicate them to the medical professional or institution.

The role of the family in the transmission of the deceased's will is especially important where the deceased was incapable of expressing his or her wishes at the time of hospitalization.[942]

It is unclear whether such language imposes a duty on the medical team to confer with or consult the families of deceased donors who have filed no objection in the registry.[943] A duty to consult may be a practical means of accommodating the wide forms of proof that the French presumed-consent law seems to contemplate.[944] Familial confirmation may thus advance accuracy. Yet, it may also frustrate a theory of presumed consent that aims to minimize family involvement. A result may be that it undermines procurement efficiency.

In practice, French medical teams continue to solicit the consent of the families of deceased potential donors.[945] This is perhaps due to custom, to tensions in presumed-consent theory, to corresponding ambiguities in the law and its implementing regulations and to the clinical and psychological reality of sensitively dealing with bereaved families.[946] When families are consulted, the law is clear about the grounds on which they may object to procurement. A case decided seven years after enactment of the presumed-consent law has firmly established that it does not provide relatives with a right to refuse based on their own objections.[947] Hence, while the deceased's expressed religious practices may provide legal grounds for non-consent, a father's distaste for invasive high technology medicine does not.

After lengthy musings about retaining presumed consent, a government committee has recently offered minor amendments to the French organ transplant law in a global legislative proposal to define the legal-bioethical status of the human body in the face of galloping changes in medical science.[948] The proposed legislation retains presumed

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942. *Circulaire du 3 avril 1978*, *supra*, note 938 at 1532.

943. See *Décret n° 78-501 du 31 mars 1978*, *supra*, note 938, s. 10.

944. See *ibid.*, ss 8-10.

945. Conseil d'État, *supra*, note 941 at 39.

946. See *ibid.*

947. See Cons. d'État, 18 March 1983, *Mme Nguyen Ti Nam, épouse Trans Van Oanh*, J.C.P. 1983.II.20111; Ruth Redmond-Cooper, "Transplants Opting Out or In — The Implications" (1984) 134 New L.J. 648.

948. See Conseil d'État, *Avant-projet de loi sur les sciences de la vie et les droits de l'homme* (Paris, 1988). See also Jean-Michel Dubernard et Jean-François Mattéi, "Bioéthique: l'urgence d'un débat au Parlement" *Le Monde* (18 April 1990) 15. The proposed legislation resulted from an extensive governmental report. See Conseil d'État, *supra*, note 941.

consent, reaffirms a gift-based ethic for tissue transfers and emphasizes the role of the family in post-mortem organ procurement. Even amidst the process of preparing and proposing this global legislative approach, French society has devoted increased attention to regulating the development, diffusion and costs of transplant technology.[949]

Thus, while the global approach may distinguish the French legislative proposal, the societal issues before France mirror those facing North America. The parents of a Muslim child, who became the subject of post-mortem medical interventions violative of Islamic religious beliefs, recently instituted a lawsuit that clarified the contours of presumed consent for minors.[950] Tissue safety is a continuing concern, as illustrated by the recent judicial award of damages to the family of a transplant recipient who died of rabies contracted from negligently screened eye tissue.[951] Concern and conflict have also surrounded the concept of death. Shortly after the National Academy of Medicine of France endorsed "brain death" as the preferred death terminology for transplants,[952] criminal battery charges were considered in the case of a twenty-four-year-old brain-dead patient who was mechanically maintained and experimented on, without anyone's consent, by a hospital physician.[953] While French commentators dispute whether a new human experimentation law applies to non-consensual experimental interventions on such neomorts,[954] the French National Bioethics Committee has advised against so applying presumed-consent notions.[955] The Committee has also begun addressing tissue ownership and control issues,[956] admist some rare and compelling French legal disputes involving tissue banks and depositors.[957]

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949. See *Décret n° 90-844 du 24 septembre 1990*, *supra*, note 938; *Décret n° 90-845 du 24 septembre 1990*, J.O., 25 September 1990, 11607, and six specific regulations (*arrêtés*) on waiting lists, numbers of transplant centres, etc. in J.O., 25 September 1990, 11607-10.

950. See Conseil d'État, 17 February 1988, *Époux Camara*, J.C.P. 1990.II.21421 (holding French transplant law to require express consent of legal representative of deceased minor as condition precedent to procuring organs for transplant).

951. Cour d'Appel de Paris, 19 June 1989, *Zanne* v. *Banque Française des Yeux/ Hôpital Lariboisière* [unreported]; Monique Raux, "Un chercheur nancéien était mort de la rage après une greffe de la cornée" *Le Monde* (20 June 1989) 34.

952. "National Academy of Medicine of France Adopts Statement on 'Brain Death'" (1988) 39:3 Int'l Dig. Health Leg. 762 (rejecting traditional term *coma dépassé* as ambiguous).

953. See chap. 3, section II.C(3), above.

954. Compare "L'expérimentation sur les comateux", *supra*, note 717 and Jean-Marie Auby, "La Loi du 20 décembre 1988 relative à la protection des personnes qui se prêtent à des recherches biomédicales" J.C.P. 1989.I.3384, para. 14.

955. See *supra*, note 718.

956. Comité Consultatif National d'Éthique pour les Sciences de la Vie et de la Santé, "Avis sur les problèmes posés par le développement des méthodes d'utilisation de cellules humaines et de leurs dérivés" in *Éthique et recherche biomédicale: rapport 1987* (Paris: La Documentation française, 1988) at 18-21 (tentatively finding that (1) patients may be thought to consent, impliedly, to the commercial development and utilization of cells contained in diseased tissue; (2) it is nonetheless advisable that they be informed of such potential use; (3) the patient sources of commercially cultivated, developed cells have no commercial interests in the resulting product; and (4) biomedical researchers sales of cell lines do not commercialize the human body). Compare *Moore* (1990), *supra*, note 426.

957. Compare *Parpalaix*, *supra*, note 417; Jean-Yves Nau, "Engendrer après la mort" *Le Monde* (17 January 1990) 17 (widow suing French sperm bank for the post-mortem restitution of the frozen sperm of husband, who had deposited sperm in the course of testicular cancer treatment, but who later died of AIDS) and "Rejet d'une demande d'insémination post-mortem" *Le Monde* (27 March 1991) 24.

B. Belgium

In 1986, Belgium enacted presumed-consent legislation that both parallels and differs in scope and impact from the French transplant legislation.[958] First, in contrast to the modest long-term impact of the French law, preliminary accounts of the workings of the Belgian law suggest that post-mortem organ procurement has nearly doubled.[959] This parallels the reported impact of recent presumed-consent legislation for corneal transplants in the United States.[960]

Secondly, the Belgian law differs from the French law in terms of its scope. The French post-mortem organ procurement Act explicitly exempts from presumed consent minors, the mentally disabled and others thought to be incapable of meaningfully registering their intentions.[961] The Belgian Act seems not to mention explicitly the mentally disabled, but its presumption of consent does apply to minors.[962] Thus, if the French legal representative does not authorize consent, post-mortem procurement may not proceed. If the Belgian legal representative does not object, procurement may proceed. Finally, the Belgian law parallels the French law by authorizing the families of the deceased to withhold consent to donation, so long as the objection does not override the expressed wishes of the donor.[963]

C. Council of Europe

As the French and Belgian experiences perhaps suggest, defining the family role in post-mortem tissue procurement has proven an equally sensitive issue in other Western European countries, many of which belong to the Council of Europe. Established in post-World-War-II Europe to promote human rights,[964] the Council of Europe has

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958. *Law of 13 June 1986*, *supra*, note 935. For recent tissue bank regulations promulgated pursuant to the 1986 law, see "Crown Order of 15 April 1988 on Tissue Banks and the Removal, Preservation, Preparation, Importation, Transport, Distribution, and Supply of Tissues", reproduced in (1990) 41:1 Int'l Dig. Health Leg. 36.

959. Georges Binamé, "Organ Transplantation: A Chronicle of a Long-Awaited Law" (1990) 41:2 Int'l Dig. Health Leg. 336 at 338; L. Roels et al., "Effect of Presumed Consent Law on Organ Retrieval in Belgium" (1990) 22:4 Transplant. Proc. 2078.

960. See text accompanying note 1008, *infra*.

961. See *Époux Camara*, *supra*, note 950. See also Conseil d'État, *supra*, note 941 at 36.

962. See *Law of 13 June 1986*, *supra*, note 935, s. 10.2. Such a presumption might raise a *Charter* issue in Canada.

963. See *ibid.*, s. 10. Quasi-presumed consent laws that provide the deceased or his or her family a right of informed refusal have been termed "routine removal" laws. See Arthur J. Mattas et al., "A Proposal for Cadaver Organ Procurement: Routine Removal with Right of Informed Refusal" (1985) 10 J. Health Pol. Pol'y L. 231.

964. See European *Convention for the Protection of Human Rights and Fundamental Freedoms*, 4 November 1950 (1955) 213 U.N.T.S. 221 (entry into force 3 September 1953). Parties to the Convention are Austria, Belgium, Cyprus, Denmark, Finland, France, West Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, the Netherlands, Norway, Portugal, San Marino, Spain, Sweden, Switzerland, Turkey and the United Kingdom.

issued recommendations on organ transplantation and international tissue transfers. The Council has proposed recommended texts in an effort to harmonize legislative initiatives and general policy among its twenty-two member states. General principles include: (1) express consent for tissue donation involving living donors; (2) general recognition of the whole-brain-death standard; (3) presumed consent for tissue donation involving deceased donors; and (4) a prohibition on "for profit" tissue and organ exchanges that exempts from the prohibition reimbursement for living donors' lost income or expenses resulting from donation.[965] The Council has also proposed an agreement on the international exchange and transportation of human therapeutic substances, to facilitate exchanges between the member states.[966]

As a European human rights forum, the Council has declared that European organ procurement should be facilitated in a manner consistent with "individual rights and freedoms."[967] In this vein, it is interesting to note that thirteen of its twenty-two member states have adopted a presumed-consent approach to organ procurement from cadavers.[968] Such presumed consent is based on the scarcity of organs, the lives that may potentially be saved by increasing the organ supply and a view that the dead body has no rights, although it is entitled to respect:[969]

> So, when the right to life and health of the deceased person awaiting transplantation comes into conflict with the supposed "right" of a cadaver which is no longer a person, the right of the living recipient is certainly predominant over that of the dead donor. The interest of the community prevails over that of the individual dead body.[970]

This balancing of interests might appear to slight the concerns of the family of the deceased. Under Austrian and Luxembourgian presumed-consent laws, for example, the views of the family or close relations are not taken into account.[971] Still, the Council's analysis has revealed that, in practice, many of its member countries are reluctant to apply strict presumed-consent notions.[972] This reality suggests that the practice in Belgium and

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965. Council of Europe, "Third Conference of European Health Ministers (Paris, 16-17 November 1987)" (Final Text on Organ Transplantation) (1988) 39:1 Int'l Dig. Health Leg. 274 [hereinafter Final Text], and note 971, *infra*. See also Council of Europe, "Resolution (78)29 on Harmonisation of Legislations of Member States Relating to Removal, Grafting and Transplantation of Human Substances" (1978) 29:4 Int'l Dig. Health Leg. 898.

966. Council of Europe, "Recommendation No. R(79) of the Committee of Ministers to the Member States concerning International Exchange and Transportation of Human Substances" (1979) 30:4 Int'l Dig. Health Leg. 931.

967. See Final Text, *supra*, note 965 at 275.

968. See Council of Europe, Conference of European Health Ministers, *Organ Transplantation: Third Report, Legislative Measures in Relation to Organ Transplantation and to European Co-operation* (Strasbourg: The Council, 1987) at 7.

969. *Ibid.*

970. *Ibid.*

971. Council of Europe, Conference of European Health Ministers, *Organ Transplantation: Current Legislation in Council of Europe Member States and Finland and Results of European Co-operation* (Strasbourg: The Council, 1987) at 27, 29.

972. Council of Europe, *supra*, note 968 at 7.

France is perhaps illustrative of general practice in Council of Europe member states: "[The] practice in most countries shows that the relatives are consulted and though in most cases its opinion is legally not overriding, none would go against the expressed refusal of the family."[973] The Council has recommended further study of the family's role in final decisions regarding removal of a decedent's organs.[974] Whether such study will lead to changes that increase European organ procurement rates remains to be seen. In the meantime, as in North America, European transplant waiting lists continue to grow.[975]

III. The United States: Required Request and Routine Inquiry

In recent times, a consensus has emerged in United States law and public policy regarding tissue transfer and organ procurement: namely, that organ scarcity is acute, that the sale of organs is impermissible and should be prohibited, and that potential remedies to organ scarcity should be both practical and ethically founded on encouraged altruism. These policies are expressed in a wave of tissue transfer and procurement legislation that has swept the United States over the last five years.

One commentator has described the legislative approach adopted in the United States as follows:

> The statutes promote the recognition of potential donors and either require that people or the next of kin be asked to donate a dying or dead relative's organs or that they be informed of donation options. . . . [A] routine inquiry policy requires neither that an unwilling person make a request, nor that the families be asked to donate. Rather, this policy requires hospitals to adopt procedures to assure that the family is offered the opportunity to donate.[976]

Over forty-four United States jurisdictions have adopted such laws since their initial enactment in Oregon, California and New York in 1985.[977] As suggested, the laws usually adopt either a routine-inquiry or required-request approach to undeclared donor circumstances. Routine-inquiry statutes have been regarded as taking the softer approach. They require hospitals to develop protocols for ensuring that families of undeclared potential donors are offered the opportunity or informed option of donation.[978] Required-request

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973. Council of Europe, *supra*, note 971 at 26.

974. Council of Europe, *supra*, note 968 at 9.

975. See B. Cohen, "Rapid Changes in the Work of an International Exchange Organization: Eurotransplant" (1988) 20:5 Transplant. Proc. 817, 818 and Council of Europe (November 1990) 2 Transplant 161. See also Jeffrey M. Prottas, "Organ Procurement in Europe and the United States" (1985) 63 Milbank Mem. Fund Q. 94.

976. Daphne Sipes, "Requesting Organ Donations: A New State Approach to Organ Transplants" (1987) 8:2 Health L. Can. 39 at 40.

977. Kathleen S. Andersen and Daniel M. Fox, "The Impact of Routine Inquiry Laws and Organ Donation" (1988) 7 Health Aff. 65.

978. American Hospital Association, American Medical Association, United Network for Organ Sharing, *Required Request Legislation: A Guide for Hospitals on Organ & Tissue Donation* (AHA, AMA, UNOS, 1988) at 1.

laws are more strongly worded. They oblige hospitals to adopt protocols to ensure that families of potential donors are actually asked to donate.[979]

Why has the United States so broadly endorsed this approach? The endorsement reflects a consensus on the major causes of, and preferred remedies to, organ and tissue scarcity. The remedy — the legislative duty to inquire — targets one of the most delicate and psychologically burdensome areas of organ donation and procurement: namely, approaching the family of a recently deceased individual who has been identified as a potential organ donor. It is designed to address an identified problem. American and Canadian studies and reports have documented the high reluctance of health professionals to approach families in such situations.[980] Canadian federal and provincial task forces have characterized the reluctance as a "major, significant" barrier to increasing donation.[981] American analysts share this view. In 1985, a special Hastings Center report found "the failure to ask about donation, the failure to recognize the key role played by family members" to be key, important hindrances to donation.[982] The report recommended legislative enactment of soft required-request or routine-inquiry statutes.[983] The Hastings Center and Canadian task force findings were echoed two years later by an organ transplant task force in the United States:

> *The Task Force finds that a major problem with the current voluntary system of organ donation is that families often are not informed of their option to donate organs and tissues after brain death is determined.* Because many families are unaware of this option, it is likely that more organs could be procured while honoring the legal commitment to voluntary consent if family members were routinely informed of the opportunity to donate organs and tissues at the time of death of a relative. . . .
>
> *The Task Force recommends that all health professionals involved in caring for potential organ and tissue donors voluntarily accept the responsibility for identifying* these donors and for referring such donors to appropriate organ procurement organizations. . . .
>
> The Task Force *recommends that hospitals adopt routine inquiry/required request policies and procedures for identifying potential organ and tissue donors and for providing next of kin with appropriate opportunities for donation.* . . .
>
> Although the concept is often called "required request," a routine inquiry policy requires neither that an unwilling person make the request, nor that families be *asked* to donate. Rather, this policy requires hospitals to adopt procedures to assure that the family is *offered* the opportunity to donate. The distinction is important because people react more positively when offered a choice.[984]

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979. *Ibid.*

980. See text accompanying notes 228-233, *infra*.

981. *Ibid.*

982. The Hastings Center, *Ethical, Legal and Policy Issues Pertaining to Solid Organ Procurement* (Hastings-on-Hudson, N.Y.: The Center, 1985) at 15.

983. *Ibid.* at 21-22.

984. USTF, *supra*, note 29 at 31, 33, 32 (emphasis added).

The task force supported its recommendation by a finding that most families of undeclared potential donors do not object to being approached; indeed, they may welcome it as part of their bereavement process.[985]

The United States endorsement of routine inquiry or required request also reflects the view that it is a preferred public policy option. When compared to a free or regulated market of organ sales[986] and a presumed-consent approach to cadaver organ procurement, the routine-inquiry or required-request approach is seen as more respectful of altruism, familial sentiments and religious interests.[987] While it generally removes the option not to inquire, it does permit families the right to decline.[988] The policy presumes that the problem lies not with engendering altruism but with helping people to act on their good intentions.[989]

The novelty of routine-inquiry and required-request legislation precludes an assessment of its effectiveness. Indeed, the evidence of its effects on organ procurement still remains inconclusive. On the one hand, some professions have criticized the laws as impinging on necessary professional discretion, family autonomy and privacy, and as being a step in the direction of more coercive organ procurement measures.[990] On the other hand, some increases in tissue and organ donation have been recorded. For example, eye banks in Oregon reported a 135-per-cent increase in donor eye procurement.[991] A New York skin bank has experienced a 180-per-cent increase in skin donations.[992] Increases in organ procurement and referrals have also been reported in California[993] and Michigan.[994]

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985. *Ibid.* at 32 ("Organ donation and tissue donation is almost always a profound source of consolation to families of patients suffering unexpected and premature death"). See also Batten and Prottas, *supra*, note 227 at 38 (86% of surveyed donor families' main motivation to donate was to make "something positive come out of death").

986. See generally Note, "Regulating the Sale of Human Organs" (1985) 71 Va L. Rev. 1015.

987. See Arthur L. Caplan, "Ethical and Policy Issues in the Procurement of Cadaver Organs for Transplantation" (1984) 311:15 N. Engl. J. Med. 981 at 982.

988. See *ibid.*

989. See Jeffrey M. Prottas, "Encouraging Altruism: Public Attitudes and the Marketing of Organ Donation" (1983) 61 Milbank Mem. Fund Q. 278 at 279.

990. See, *e.g.*, Susan Martyn, Richard Wright and Leo Clark, "Required Request for Organ Donation: Moral, Clinical, and Legal Problems" (1988) 18:2 Hast. Cent. Rep. 27. But see Arthur L. Caplan, "Professional Arrogance and Public Misunderstanding" (1988) 18:2 Hast. Cent. Rep. 34.

991. See Terry E. Burris et al., "Impact of Routine Inquiry Legislation in Oregon on Eye Donations" (1987) 6:3 The Cornea 226.

992. See The New York State Task Force on Life and the Law, *Transplantation in New York State: The Procurement and Distribution of Organs and Tissues* (New York: The Task Force, 1988) at 155.

993. See Andersen and Fox, *supra*, note 977 at 76-77.

994. See Beverly Merz, "The Organ Procurement Problem: Many Causes, No Easy Solutions" (1985) 254:23 JAMA 3285 at 3287. But see Arthur L. Caplan and Beth Virnig, "Is Altruism Enough? Required Request and the Donation of Cadaver Organs and Tissues in the United States" (1990) 6:4 Critical Care Clinics 1007 at 1011 (mixed results).

Although the early initiatives for required request came from particular states, both uniform and federal organ transplant legislation has helped to encourage further enactment of such laws. The *National Organ Transplant Act* (NOTA) of 1984[995] was enacted by the United States Congress to facilitate and improve the national procurement and sharing of organs. The Act (1) established the national task force to study organ procurement and transplantation; (2) established a national computer registry for organ exchange data; (3) provides assistance to regional organ procurement activities; (4) established a national bone marrow donor registry;[996] (5) imposes a $50,000 fine or five years' imprisonment or both for the knowing transfer, in interstate commerce, of an organ (kidney, liver, heart, lung, pancreas, bone marrow, cornea, eye, bone or skin, but not blood) for valuable consideration; and (6) following the recommendations of the United States task force, requires hospitals receiving federal funds to adopt written protocols to identify organ donors.[997]

Several other aspects of the legislation are noteworthy. First, the sales prohibition and definition of human "organ" generally do not include replenishable tissues whose donation do not pose physical risks to the donor.[998] Recent amendments to the Act have expressly included "fetal organs" or "subparts of" other organs within the statutory prohibition on sales.[999] Secondly, as in the recent British and Manitoba legislation and the Council of Europe recommendation, the prohibition on "sales" does not exclude payment for retrieval, processing, preservation, transportation expenses or the donor's travel, housing or lost wages.[1000] Thirdly, related federal legislation has apparently given

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995. Pub. L. No. 98-507, 98 Stat. 2339 (codified, *inter alia*, as am., at 42 USCS §§ 273, 274, 1320b-8) [hereinafter NOTA].

996. While the registry appears to be approaching its goal of 100,000 registered donors, that figure may still not satisfy U.S. needs. See "Program to Find Marrow Donors Is Falling Short" *New York Times* (11 December 1989) A18. See also "Transplant Reward Offer Raises Furor" *New York Times* (23 June 1989) A6 ($5,000 offered to attract matching bone marrow donor); "Girl Born to Couple Who Seek Marrow Donor" *New York Times* (7 April 1990) 8 (couple conceives to transplant baby's bone marrow into teenaged daughter dying from leukemia). See also *Transplant Amendments Act of 1990*, Pub. L. No. 101-616, 104 Stat. 3279 (to be codified at 42 USCS § 301), which are intended to strengthen the national bone marrow donor registry.

997. See U.S. Organ Procurement Protocols, 53 Fed. Reg. 6,526, 6,527, 6,544 (1March 1988) (to be codified at 42 C.F.R.).

998. See U.S. Code Cong. & Ad. News, *supra*, note 481 at 3982 ("It is the sense of the Committee that individuals or organizations should not profit by the sale of human organs for transplantation. This is not meant to include blood and blood derivatives, which can be replenished and whose donation does not compromise the health of the donor."). The logic of the distinction may be buttressed by the view that the invasive nature and associated risks of bone marrow or skin transplantation make the procedures more akin to vital organ transplantation than to blood or sperm donation: hence, their inclusion in the definition of "organ" for the sales prohibition. It should also be noted that while the federal organ sales ban applies to tissue from living and deceased "donors," the sales ban proposed under model uniform law applies only to cadaveric tissue. Compare NOTA, *supra*, note 995, § 274e and UAGA, *infra*, note 1004, s. 10.

999. *Organ Transplant Amendments Act of 1988*, Pub. L. No. 100-607, s. 407, 102 Stat. 3114 (1988) (amending 42 USCS, § 274e(c)(1)).

1000. See 42 USCS, § 274e.

the states discretion in their choices to fund or not to fund transplants, and those financial decisions have become the subject of transplant funding litigation.[1001]

Finally, regulations adopted under NOTA have established a National Organ Procurement and Transplantation Network, which involves some seventy certified organ procurement agencies in eleven designated regions across the United States. The national organ procurement system is administered by the United Network for Organ Sharing (UNOS), a private organization under contract to the United States Department of Health and Human Services[1002] and overseen by it. Under the auspices of that department, UNOS develops national policies and procedures, through public commentary and various national committees. Thus, for example, UNOS Foreign Relations Committee deliberations have helped shape international organ-sharing policies of the United States through UNOS policies, which generally : (1) prohibit the exportation of United States organs beyond North America, unless a suitable United States recipient cannot be found; (2) permit transplant centres in the United States to enter into formal organ exchange protocols with UNOS-registered and -approved foreign transplant centres; (3) otherwise prohibit the ad hoc importation of organs, unless it is co-ordinated through or approved by UNOS; and (4) subject to audit those centres that perform more than 10 per cent of their annual transplants on non-resident alien recipients.[1003]

Legislative provisions that parallel NOTA have been adopted under recent amendments to model, uniform anatomical gift legislation in the United States. In 1987, the twenty-year-old model gift tissue law was amended.[1004] While the new Uniform Act adopts the routine-inquiry principle,[1005] it also adopts a quasi-presumed-consent provision. The provision permits a coroner or medical examiner to authorize the removal of bodily parts from a body lawfully in the custody of the examiner, once a "reasonable effort, taking into account the useful life of the part," has been made to contact the deceased's next of kin.[1006] The duty to make a reasonable effort to contact the family of the deceased

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1001. Compare *Ellis* v. *Patterson*, 859 F. 2d 52 (8th Cir. 1988) (finding 1986 U.S. medicare amendments, to 42 USCS, § 1396b(i), give states discretion to fund, not fund, or limit funding of organ transplants, and require that limitations be neither arbitrary nor unreasonable); *Todd* v. *Sorrell*, 841 F. 2d 87 (4th Cir. 1988) (requiring state to pay patient's liver transplant costs); *Montoya* v. *Johnston*, 654 F. Supp. 511 (W.D. Tex. 1987) (finding $50,000 cap on state funded hospital expenses arbitrary and unreasonable exclusion of coverage for child requiring a $100,000 to $200,000 liver transplant). For review of U.S. government bases for funding liver transplants, see 56 Fed. Reg. 15,006 (12 April 1991). Private insurers are also not immune from transplant funding litigation. See *Dozsa* v. *Crum & Forster Insurance Co.*, 716 F. Supp. 131 (D. N.J. 1989) (requiring coverage of bone marrow transplants).

1002. See John C. McDonald, "The National Organ Procurement and Transplantation Network" (1988) 259:5 JAMA 725.

1003. See *UNOS Policy on Transplantation of Foreign Nationals* (6.0-6.6) (effective July 1991). See also *UNOS Policies: Changes as of December 6, 1988* (3.14) (U.S.-Canadian Interim Organ Sharing Agreement expired). For further discussion of restricting foreign patient access to U.S. transplant waiting lists, see USTF, *supra*, note 29 at 93-95. See also Medicare Program; Payment for Kidneys Sent to Foreign Countries or Transplanted in Patients Other Than Medicare Beneficiaries, 42 C.F.R. pt. 413.179.

1004. See *Uniform Anatomical Gift Act (1987)*, 8A U.L.A. (1990 Supp.) [hereinafter UAGA], discussed in A. McIntosh, "Regulating the 'Gift of Life' — The 1987 Uniform Anatomical Gift Act" (1990) 65:1 Wash. L. Rev. 171. See also *Uniform Determination of Death Act (1980)*, 12 U.L.A. 320 (1990 Supp.) (adopted in most jurisdictions).

1005. UAGA, *supra*, note 1004, s. 5.

1006. *Ibid.*, s. 4.

should help to avoid the civil and constitutional challenges that have been lodged against presumed-consent practices and laws for eye tissue procurement in some United States jurisdictions.[1007] The UAGA provision significantly expands the presumed-consent approach for eye tissue to include procurement of bodily parts. That approach was adopted on the view that such legislation advances legitimate state interests in the protection of health and preservation of life, and on evidence that such laws have resulted in increases in transplantations (for example, in Florida an increase from 500 to 3,000 corneal transplants).[1008] A minority of American jurisdictions have thus far adopted the new Uniform Act.[1009]

IV. Australia: Presumed Consent Following Required Inquiry

As a result of recommendations of the Australian Law Reform Commission[1010] (ALRC), most Australian hospitals approach declared cadaveric donor and undeclared donor circumstances in a uniform manner. First, the ALRC recommended that hospitals be authorized to procure tissue and organs from explicitly declared donors, despite potential objections from surviving family members.[1011] The practice is based on the ethical principles of autonomy and beneficence: respecting the wishes of the deceased person and furthering the medical needs of transplant recipients.[1012] Secondly, the ALRC recommended that hospitals be authorized to procure tissue from undeclared potential donors, if hospitals first make reasonable inquiries:

> Where a person dies in hospital or his body is brought into a hospital, the hospital itself, by a designated officer, should have the power to authorise removal of tissue for transplant or the other purposes described above after first making inquiry for the existence of consent and objection by the deceased, or, if none exists or can be ascertained, objection by relatives. The terms of any consent or objection of the deceased will have effect. The hospital's duty of inquiry should be to make "such inquiry as may be reasonable in the circumstances."[1013]

1007. Such states as Florida, Michigan, Texas and Ohio have followed the 1975 legislative model of Maryland, by authorizing procurement of eye tissue when: (1) a body is under the jurisdiction of the coroner for forensic autopsy purposes; (2) there is no "known objection" to corneal tissue procurement; and (3) procurement would result in neither disfigurement/mutilation of the body nor in interference with the autopsy. See Md Est. & Trusts Code Ann. s. 4-509.1 (1989 Supp.). Suits have been filed against procurement activities that have relied on the "no known objection" language to procure without giving families of the deceased a meaningful opportunity to object. See *Brotherton*, *supra*, note 894; *Kirker*, *supra*, note 403; *Powell*, *supra*, note 895; *Georgia Lions Eye Bank*, *supra*, note 894, *Tillman*, *supra*, note 894. Compare the "good faith" attempt to contact family required under Massachusetts eye tissue procurement law, Mass. Gen. Laws Ann., c. 113, s. 14 (1989 Supp.), and recent legislative changes in Rhode Island — R.I. Gen. Laws, c. 4, s. 23-4-4.1 (Michie 1990 Supp.) — the latter of which was prompted by *You Vang Yang*, *supra*, note 900.

1008. See UAGA, *supra*, note 1004, s. 4, comment.

1009. See UAGA, *supra*, note 1004.

1010. Australian Law Reform Commission, *Human Tissue Transplants*, Report 7 (Brisbane: Watson Ferguson and Co., 1977) [hereinafter ALRC].

1011. *Ibid.*, para. 144, at 65-66.

1012. *Ibid.*, para. 140 at 64. See also chap. 3, above.

1013. *Ibid.*, para. 144 at 66.

The ALRC proposal would seem to strike a middle course between the routine-inquiry and required-request approaches of the United States and the presumed-consent approach of western Europe for undeclared donor circumstances. It parallels the general approach of the United States, by conditioning procurement on an attempt to consult the family, to whose consent or objection the hospital must defer. However, it diverges from the general view of the United States, and parallels a minority view in North America, in that it presumes consent if family members cannot reasonably be ascertained or contacted.[1014] By so presuming consent, the ALRC recommendation parallels the general western European approach. However, it also diverges from that approach because it explicitly requires an attempt to consult the family, and makes familial objections binding, apparently whatever their basis.[1015]

The ALRC recommendations have prompted legislative reform. Between 1978 and 1985, all eight states of Australia substantially adopted the ALRC recommendations; a majority of them specifically adopted the ALRC's "required inquiry followed by presumed consent" approach to undeclared donor circumstances.[1016] Since that approach usually results in consultation with the family of the deceased undeclared potential donor, national efforts have been undertaken to ensure that hospitals fulfil this societal function in a sensitive and effective manner.[1017] The ALRC tissue sales recommendation — that is, forbid payment for tissue, but authorize payments for tissue processing services and for reimbursement of donor expenses — has also been implemented.[1018]

V. International Concerns

Advances in tissue replacement technology, which have spawned recent law reform

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1014. Compare section IV and text accompanying note 1007, *supra*.

1015. Compare section III and text accompanying notes 970-973, *supra*.

1016. *Transplantation and Anatomy Ordinance 1978*, 1978 L. Austr. Cap. Terr., No. 44, s. 27; *Transplantation and Anatomy Act 1979*, 1979 S. Qld, No. 74, s. 26; *Human Tissue Act 1982*, 1982 A. Vic., No. 9860, s. 26; *Human Tissue Transplant Act 1979*, 1979 N. Terr., No. 121, s. 18; *Human Tissue and Transplant Act, 1982*, 1982 S. W. Austr., No. 116, s. 22; *Anatomy (Human Tissue) Amendment Act, 1983*, 1983 S. N.S.W., No. 165, s. 3; *Transplantation and Anatomy Act, 1983*, 1983 S. S. Austr., No. 11, s. 21; *The Human Tissue Act 1985*, 1985/86 S.L. Tasm., No. 118, s. 23; (1987) 38:3 Int'l Dig. Health Leg. 510. In contrast to the quasi-presumed-consent approach of most Australian jurisdictions, language in the Western Australian and Tasmanian statutes would seem to indicate that if the hospital cannot locate family members of an undeclared donor, to receive their non-objection, tissue procurement may not proceed. See Western Australian and Tasmanian statutes, *ibid.*, ss 22(3) and 23(2) respectively.

1017. See National Health and Medical Research Council, *A Code of Practice for Transplantation of Cadaveric Organs* (Canberra: The Council, 1982) at 8-9 ("Any approach should be made with proper sensitivity and a feeling for the relatives' distress. Their views should be sought whenever possible at a personal interview but there may be occasions when the only practical means of discussing the matter is by telephone. . . . It has been found in practice that relatives, on an initial approach, may refuse permission but may change their minds later after they have thought and felt their way through the idea. It should be remembered that where permission is given by relatives, this constitutes not only a gift of the deceased, but their gift in part as well. Bereavement counselling should also be offered, as there is now good evidence of increased morbidity and mortality in the year following unresolved grief.").

1018. Compare ALRC, *supra*, note 1010, para. 178 at 87(recommending legal prohibition on payment for removal of tissue, except for reimbursement of associated expenses or to suppliers of donated tissue processed/prepared for medical use) with tissue sales prohibitions in the statutes, *supra*, note 1016.

in several nations, have also had an impact beyond national frontiers. Indeed, concerns over the safety, sales and control of tissue transfers have prompted initiatives indicative of evolving international public policy and law.

A. Transnational Transfers

The ebb and flow of national tissue needs may occasion recourse to international transfers. Early nineteenth-century anatomical needs, for example, were sometimes addressed by Canadian-American and Irish-Scottish-English exchanges of dead bodies.[1019] Changes in medical needs have meant changes in import-export patterns. In 1987, Baby Gabriel, a moribund anencephalic newborn from Ontario, helped expand the United States organ donor pool when his organs were donated to Baby Paul in California.[1020] In a six-month period in 1988, 9 per cent of the bone issued by the University of Toronto Bone Bank was exported to countries such as Australia.[1021] In the two-year period, 1988 and 1989, over ninety kidneys, hearts and livers crossed the Canada-United States border.[1022] For years, human sperm has been imported into Canada to assist in modern infertility treatment.[1023] Moreover, international collaboration is now deemed "essential" for Canadian bone marrow transplant needs.[1024] In short, some of the extraterritorial flow owes to the benefits of expanded, international donor and recipient pools for satisfying national supply and demand.

Some of the international flow arises more specifically from insufficient technology to satisfy national medical needs. The constraint sometimes prompts patients to seek therapy abroad. Before pediatric liver transplants became available domestically, for example, Canadian physicians referred children to centres in the United States within minimal flying time of Canada. Similarly, Canadian surgeons have recently performed transplants on patients from Japan, where religious taboos concerning the dead body apparently have restrained the development of indigenous transplant technology.[1025] The "technology" constraint may also necessitate tissue imports. Canadian hemophiliacs, for example, continue to rely heavily on blood clotting factors that are manufactured in the United States and exported to Canada, largely because blood fractionation technology remains scant in Canada.[1026] Similarly, from 1988 through 1989 Canadian heart surgeons sent more than

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1019. Compare Lawrence, *supra*, note 4 at 414 and "On the Exportation of Dead Bodies from Ireland to England and Scotland" (1828-29) 1 Lancet 775 (letter).

1020. See Scott, *supra*, note 579.

1021. "Bone Bank in Desperate Search for New 'Depositors'" *The Medical Post* (21 March 1989) 39.

1022. HWC, *supra*, note 59.

1023. See Christie McLaren, "Large Ethnic Market in U.S. Creates High Interest in Toronto Sperm Bank" *The [Toronto] Globe and Mail* (19 May 1990) A1 at A2 (Canada-U.S. sperm trade). See also *Report of the Advisory Committee*, *supra*, note 161 at 14 (urging prohibition on imported sperm until federal standards are established).

1024. See Noël A. Buskard, "The Canadian Unrelated Bone Marrow Donor Registry" (1990) 7 Transplantation/Implantation Today 42.

1025. David Helwig, "Canadian Doctors and Japanese Tot Help Change Japanese Attitudes on Transplants" (1988) 139:1 C.M.A.J. 1088.

1026. See CBC, *supra*, note 35 at 17.

200 human heart valves to a tissue bank in the United States for intricate processing and initial storage, prior to their use in Canadian heart valve replacement surgery.[1027] As tissue preservation, transportation and international procurement systems advance, transnational exchanges may well increase. As variances in domestic technology continue in the face of international medical need, countries will sometimes be net exporters and sometimes net importers of both procured tissue and transplant recipients.

B. Safety

If international transfers contribute towards satisfying global therapeutic needs, they also distribute risks to continents beyond the tissue-exporting nation. Blood clotting factors processed in the United States have been implicated in the transmission of the hepatitis[1028] and AIDS viruses[1029] to Canadian hemophiliacs. Canadians have also begun settling lawsuits against the California manufacturer of defective mechanical heart valves implanted in some 8,900 Canadians and 39,000 other cardiac patients outside the United States.[1030] These statistics underline the safety dimensions of defective tissue replacement technologies that are mass-produced for use in patients abroad.

Of course, the risks of illness, injury or death from exported tissue replacement technologies extend beyond North America. In 1987, international safety alerts were issued in response to the death of an American who had received a graft of infected tissue that was procured and commercially processed in Germany, exported to Canada and imported into the United States.[1031] The tissue, used in reconstructive brain surgery, was cadaveric dura mater, a tough membrane that covers and protects the brain. Despite the international recall of the suspected material, similar deaths have been recently reported in New Zealand and Italy.[1032]

1027. HWC, *supra*, note 59.

1028. *Kitchen* v. *McMullen* (1989), 62 D.L.R. (4th) 481 (N.B.C.A.).

1029. U.S. Centers for Disease Control, "Safety of Therapeutic Products Used for Hemophilia Patients" (1988) 37:29 Morbidity Mortality Wkly Rptr 441 at 442.

1030. See Christie McLaren, "Canadian Gets Settlement for Implant Worry" *The [Toronto] Globe and Mail* (13 December 1989) A1; "F.D.A. Is Faulted on a Heart Valve" *New York Times* (26 February 1990) B8. See also, *Stangvik* v. *Shiley Inc.*, 273 Cal. Rptr. 179 (App. 4th Dist. 1990) (Norwegian and Swedish recipients), rev. granted 800 P. 2d 858; *Corrigan* v. *Bjork Shiley Corporation*, 227 Cal. Rptr. 247 (App. 2d Dist. 1986) (Australian recipient), cert. denied 479 U.S. 1049. See generally U.S. House of Representatives, Staff Report of the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce, *The Bjork-Shiley Heart Valve: "Earn as You Learn"* (Washington, D.C.: U.S. Government Printing Office, 1990).

1031. See U.S. Centers for Disease Control, "Update: Creutzfeldt-Jakob Disease in a Patient Receiving a Cadaveric Dura Mater Graft" (1987) 36:21 Morbidity Mortality Wkly Rptr 324. See also Vijay Thadani et al., "Creutzfeldt-Jakob Disease Probably Acquired from a Cadaveric Dura Mater Graft" (1988) 69:5 J. Neurosurg. 766.

1032. See U.S. Centers for Disease Control, "Creutzfeldt-Jakob Disease in a Second Patient Who Received a Cadaveric Dura Mater Graft" (1989) 261:8 JAMA 1118; Carlo Masullo et al., "Transmission of Creutzfeldt-Jakob Disease by Dural Cadaveric Graft" (1989) 71:6 J. Neurosurg. 954.

C. Sales

Whether the international community tolerates or abhors a "tissue transfer" sale seems to depend, in part, on where in the spectrum — from natural tissue to processed or manufactured tissue products — the object of sale lies. Sales of safe and effective tissue replacement technologies, such as mechanical heart valves, seem an acceptable part of international trade. Sales of commercially processed blood product derivatives may raise more objection, assuming a preference for altruistically based, or non-commercially processed, tissue derivatives. Sales of these objects nevertheless appear to be countenanced by necessity.[1033]

By far, it is the non-gift-based exchanges of natural human tissue, specifically organ sales, that most provoke concern from quarters within the international community. If higher costs fail to justify higher fees for the co-ordination of international organ shipments, the transactions may seem suspect.[1034] Allegations of Turkish-British kidney sales prompted enactment of the 1989 British organ transplant law.[1035] Former eye bank employees in Florida were convicted, in 1989, of grand theft involving the transfer of corneas for $650 apiece to Saudi Arabian interests.[1036] Allegations of Canadian-American, French-Dutch and Mexican-Canadian organ sales have recently been reported.[1037]

Yet, the difficulty in tracing and substantiating alleged international organ sales has dissuaded neither nations nor international organizations from pronouncing on the issue. Since 1980, Great Britain,[1038] Australia,[1039] the United States,[1040] the Council of Europe,[1041] Canadian provincial governments,[1042] the World Medical Association,[1043] Pan American[1044] and international transplant societies[1045] and international criminal law

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1033. Compare CBC, *supra*, note 35, and Britten, *supra*, note 203 and accompanying text.

1034. See U.S. Congress, Hearings before the Subcommittee on Investigations and Oversight of the Committee on Science and Technology, *Procurement and Allocation of Human Organs for Transplantation* (7, 9 November 1983) (Washington, D.C.: U.S. Government Printing Office, 1984) at 99 (Japan-U.S. fees).

1035. See *Human Organ Transplants Act 1989*, *supra*, note 526.

1036. See *State of Florida* v. *Grant* (19 January 1989), Hillsborough Cnty 87-4613 (Cir. Ct). See also "5 Accused of Selling Corneas" *New York Times* (12 January 1989) A24.

1037. See text accompanying notes 461-463, *supra*; Paul Taylor, "Kidneys Sold by Poor for Transplants, MD Says" *The* [*Toronto*] *Globe and Mail* (22 August 1989) A1; Alexander Dorozynski, "European Kidney Market" (1989) 299:6709 Br. Med. J. 1182.

1038. See *Human Organ Transplants Act 1989*, *supra*, note 526.

1039. See *supra*, note 1018.

1040. See NOTA, *supra*, note 995, § 274e.

1041. See *supra*, note 965.

1042. See, *e.g.*, MHTA, *supra*, note 839, s. 15.

1043. See appendix A, *infra* at 200-201.

1044. Pan American Society for Dialysis and Transplantation, "Document on Transplant Ethics" (1989) 5:2 UNOS Update 7.

1045. See The Council of the Transplantation Society, "Commercialisation in Transplantation: The Problems and Some Guidelines for Practice" (1985) 2:8457 Lancet 715.

societies,[1046] among others, have either declared organ sales ethically abhorrent or enacted penal prohibitions to deter them and punish offenders.

Whether or not the pronouncements and practices announce a rule of international public law, it is clear that the views are shared by the World Health Organization. In 1989, Canada exercised a leadership role in co-sponsoring a World Health Organization organ sales resolution which was eventually supported by more than 151 nations. The resolution urges nations to join an international effort to curb the risks and incidence of organ sales:

> The Forty-second World Health Assembly,
>
> Concerned by the commercial trafficking in the organs of healthy donors, which exploits human distress and puts at increased risk the health of the donors . . .
>
> Aware that commercial arrangements for organ transplants are nevertheless being undertaken . . .
>
> Anxious to prevent the exploitation of human distress . . .
>
> 1. CALLS UPON Member States to take appropriate measures to prevent the purchase and sale of human organs for transplantation . . .[1047]

D. International Controls

In addition to formal resolutions, the international community may pursue several options, ranging from treaties and national legislation to ethical codes of conduct, to ensure safe and adequate, speedy and ethically acceptable tissue transfers for global therapeutic needs. For instance, the ethical pronouncements of the International Council of the Transplantation Society, and World Medical Association may sketch an international code of ethical conduct for transplant physicians. The organ transplant principles that the World Health Organization is expected to adopt in 1991 may have this effect.[1048] While such pronouncements lack the force of law, they may still be given legal effect if they become the operative standard of conduct in national disciplinary proceedings, such as those undertaken by the General Medical Council of Great Britain in which doctors implicated in British-Turkish organ sales were recently found guilty of serious professional misconduct.[1049]

Beyond formal resolutions and codes of conduct, international agreements offer a direct means of controlling tissue safety and supply, organ sharing and technical information sharing, as well as offering means of applying ethical principles. The agreements may take the form of transnational contracts. For instance, the Canadian Blood Committee has

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1046. See International Association of Penal Law, "XIV International Congress on Penal Law" (1990) 5 IAPL Newsletter (Draft Resolution 3.10 on Organ Transplants and Artificial Organs) at 60.

1047. "World Health Assembly Adopts Resolution on 'Preventing the Purchase and Sale of Human Organs'" (1989) 40:3 Int'l Dig. Health Leg. 724, reproduced in part in appendix A, *infra* at 202-203.

1048. See appendix A, *infra* at 201-203.

1049. Diana Brahams, "Kidney Sales" (1990) 335:8964 Lancet 906.

contracted with American interests to process and supply anti-hemophilia blood products.[1050] Agreements may also take the form of formal treaties. An example is a Council of Europe agreement that exempts human therapeutic substances from import-export duties, on the practical view that duty-free status eases international exchange, and on the ethical view that donated human therapeutic substances are priceless.[1051] While United States and Canadian authorities have considered systemizing cross-border organ transfers,[1052] Eastern European nations have already formalized an organ-sharing treaty.[1053] Treaties may also address tissue safety, by recognizing the right to deny import entry to substances that pose undue health risks,[1054] and by providing importing nations with a right of inspection that corresponds to an exporting nation's duty to document compliance with agreed quality control procedures.[1055]

Finally, the laws and practices in the constituent nations of the international community, by definition, help to define its laws and policies. A prime example lies in the degree to which national law mandates safety standards for tissue replacement technologies that flow between nations. For instance, Canadian and American laws authorize the export of medical devices that do not meet national regulatory standards, if the exported devices are properly labelled and do not violate the laws of the importing country.[1056] Eastern European patients implanted with Canadian exported mechanical heart valves, then, must depend on the export label warning, Canadian manufacturing or professional standards, any legislative standards of their own country and the distant threat of lawsuits[1057] to minimize the likelihood of receiving a defective product. Tissue safety, however, would seem more likely ensured by minimally rigorous, international standards reflected in the laws of both exporting and importing nations. The logic of this approach extends beyond safety. For example, in the absence of clear international law, organ trafficking also seems more likely deterred by complementary prohibitions in donor and recipient nations,[1058] especially if national prohibitions are given extraterritorial application.

VI. International Trends

In all, the comparative and international law perspective casts a broader light on national

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1050. See CBC, *supra*, note 35.

1051. See Council of Europe, *supra*, note 966.

1052. See *UNOS Policies: Changes as of December 6, 1988*, *supra*, note 1003.

1053. See Council for Mutual Economic Assistance, "Agreement on the International System for Cooperation in the Field of Kidney Transplantation Known as 'Intertransplant'" (1982) 33:1 Int'l Dig. Health Leg. 23.

1054. See art. 20, *General Agreement on Tariffs and Trade*, 30 October 1947, 61 Stat. (5),(6) 1947, T.I.A.S. No. 1700, 55-61 U.N.T.S. (entry into force 1 January 1948).

1055. See European Economic Community, Council Directive No. 89/381/ECC of 14 June 1989 (on human blood products), *Official J. Eur. Commun.*, No. L 181, 28 June 1989, 44, reprinted in (1989) 40:4 Int'l Dig. Health Leg. 871, art. 3, para. 3.

1056. See FDA, *supra*, note 738, s. 37. See also 21 USC 381(e), discussed in OTA, *Federal Policies and the Medical Devices Industry* (Washington, D.C.: OTA, 1984) at 216, 219.

1057. See *Stangvik* and *Corrigan*, *supra*, note 1030 and *Kitchen*, *supra*, note 1028.

1058. See *supra*, note 929 and accompanying text.

tissue transfer issues. Ongoing legal initiatives to ensure safe and adequate, speedy and ethically acceptable tissue transfers are mirrored in both national and international communities.

The pace of legislative activity suggests that the legal framework governing tissue procurement and transplants is in the throes of moderate change. In the last decade, various nations have modified their applicable laws. The amendments have largely aimed at facilitating and regulating the transfer process, amidst dramatically increased transplant procedures and a corresponding need for scarce tissue. Some nations have begun to ponder the biotechnological implications of tissue replacement technologies.

The nations we surveyed tend to diverge most on the details of implementing commonly shared goals. Great Britain, France, Australia, the Council of Europe and the United States seem unanimous in the view that the sale of organs is so ethically abhorrent as to justify the criminal prohibition of sales. Although the precise drawing of lines differs, most nations insist on respecting human rights, the dead, religious beliefs and family wishes, in pursuing the life-preservation ethic that tissue procurement and organ transplantation promise. Most have adopted brain-death criteria. Most increasingly require hospitals to adopt protocols to facilitate tissue donation.

It is in terms of the post-mortem tissue procurement from undeclared potential donors that significant differences emerge, particularly regarding the legal role of the family. The express-consent and routine-inquiry laws of Australia, Great Britain and the United States generally require familial involvement. Competing presumed-consent theories in Western Europe have yielded laws that generally do not. Still, the actual clinical practice in Western Europe seems to involve the family; this may call into question the utility of a strict presumed-consent approach. Such small, significant differences are telling evidence of the tensions and values underlying these delicate legislative choices.

They may also suggest a simple truth: Whatever the chosen policy or law, it remains subject to the web of evolving yet constant beliefs, customs and attitudes on the human body that have coloured the human condition from the anatomical age to the transplantation and biotechnological ages.

CHAPTER FIVE

Options and Recommendations for Reform

I. The Strengths and Limits of Law

The foregoing chapters reveal the strengths and limits of law and its evolving role in responding to medical demand for the human body. Medical demand itself changes with technological innovation and changing therapeutic needs. The evolution of both law and medicine has sometimes tracked, and sometimes led, the evolution of views on the human body, as society has moved from the anatomical age of the nineteenth century into the transplantation and biotechnological ages of the present.

From the historical perspective, many of the concerns raised during deliberations on the 1843 *Anatomy Act* of the Province of Canada[1059] remain. Society continues to debate the issues surrounding bodily sales and property, respect for the dead body, the burden and fairness of laws addressing tissue scarcity and how the law might aid, and not impede, medicine in its endeavours to preserve life. The context, magnitude and implications of the concerns have changed, however.

Indeed, a century and half after the first debates on tissue transfer laws sounded in Canada, the questioning and international clamour provoked by the *Moore*[1060] case seem to signify formal rites of passage to a challenging new age in tissue transfer history. The initial phase of the journey seems to be a transitional one. In early passage through the biotechnological age, society finds itself searching to define the precise rules and applications of at least three legal regimes that seem likely to govern tissue transfer practices for the foreseeable future. The three legal regimes and their characteristics are outlined in table 3.

As indicated in table 3, a "natural" regime refers to the transfer of natural tissues, such as blood and organs. This regime is gift-based, as expressed in the word "donor." It is characterized by an ethical basis and a public policy of non-commerce, non-profit and non-property.

1059. See pages 2-3, 127-29, above.

1060. See *supra*, note 426.

TABLE 3. Tissue Transfer and Replacement Technologies: Legal Regimes

Regimes	Material Transferred	Transfer Model	Banking	Safety Standards	Ethic & Policy Discourse	Market
"Natural"	Tissues & Substances Transferred • blood • gametes • milk • organs • placenta • skin	Consent • donor & recipient Exceptions • unclaimed bodies • forensic autopsies • emergencies (Quebec) Abandoned • research & disposal	Preserved • blood • bone marrow • cells • gametes Preserved for • self/family by depositors • society	Professional Standards • milk Private Law Suits (few)	Gift Non-commerce Non-property	Non-profit (with exceptions)
"Mixed" — Biologics & Biotech-nological	Tissues, Substances & Products Transferred • bioprosthetic heart valves • cell lines & cultured cells • processed & synthetic rDNA hormones • rDNA genetic transplants • rDNA skin & organ equivalents • vaccines	Consent • Donor/source & recipient Abandoned & Commercialized • *Moore* case	Processed & Preserved • bioprosthetic veins • DNA • heart valves • semen: *Parpalaix* case Preserved for • self/family by depositor • society	Professional Standards Federal Drug, Biologics & Medical Device Law • bioprosthetic heart valves? • blood & plasma regulations • frozen, processed semen? • processed bone marrow & cartilage? • processed dura mater? • rDNA drugs (insulin, growth hormone)	Gift/Non-commerce Manufacture/Sales Property/Non-property	For Profit (with limits) Some Patents
"Artificial" & Mechanical	Products • artificial kidney • mechanical heart valves • synthetic blood • bioprosthetic veins • contact lenses	Consent • recipient • no donor	Processed & Manufactured • plasma • blood products • veins • "living" contact lenses	Federal Medical Device Law • safety & efficacy of medical & implanted devices, e.g.: • cardiac pacemakers • artificial heart, kidney • implanted insulin pumps • synthetic blood vessels • synthetic eye lenses	Manufacture/Process & Sales Commerce Property	For Profit • research • patents • marketing • sales

The artificial heart and kidney typify the products of a second regime — the "artificial-mechanical" tissue transfer legal regime. These tissue replacement technologies do not come from donors. They are products invented, designed, manufactured, marketed, sold and licensed under federal patent and medical device laws.[1061] Investment, commerce and for-profit transfers are commonplace and accepted in the ethic and policy discourse of this second regime.

For a number of years, Canadian society has been drawing on both the natural and artificial-mechanical regimes, to define a third, "mixed" tissue replacement legal regime. It operates parallel to, and simultaneously with, the above regimes. Under it, human tissues are processed or manufactured into therapeutic products. Drug companies, and now biotechnology firms, convert blood, tissue and substances from human sources into drugs, skin equivalents, bioprosthetic veins, frozen blood plasma and other useful therapeutic products. Many of these "biologics" and biotechnology products are patented, regulated and sold under federal laws. The terms "gift" and "commerce," "human substance" and "biosynthetic product," are used in the ethic and policy discourse of this mixed regime.

There is a conspicuous, increasing trend towards biosynthetic and bioprosthetic tissue replacement technologies.[1062] As biotechnology and medicine proliferate the number of therapeutic tissue products that seem to fall into the mixed regime, it is not always clear whether the products should be subject to the particular requirements of one or another regime. As a result, society observes the parties in *Moore*-[1063]like disputes drawing on both the natural and the artificial regime, to contest the precise legal content and consequences of the tissue transfer process. Disputes of this kind both stimulate and reflect broader societal dialogue. As such, the dialogue between law, medicine and, now, bioethics continues, and promises to do so into the twenty-first century.

The contents and dynamic of the dialogue also suggest that tissue scarcity today is as much a societal construct as an empirical fact.[1064] If disease and injury create incipient medical needs, it is also true that sophisticated surgical techniques and high technology medicine help amplify those needs into societal demand. On the supply side, annual death statistics indicate an abundant potential supply of cadaveric tissue and organs. Why cannot society simply and efficiently procure these tissues to help save human life?

To endeavour to tap this potential reservoir, however, is to encounter a technological and ethico-legal construct. Society currently lacks the technical capacity to provide long-term storage or banking of donated hearts, kidneys and lungs.[1065] In contrast to procuring simple tissues, organ procurement thus proceeds on a quasi-emergency basis to procure fresh organs from the recently deceased. Even if the technological constraint in organ banking were relaxed, procurement would encounter an ethico-legal construct.

1061. See pages 20-23, 117 and 123 above.

1062. See pages 22, 117-22 above.

1063. See *Moore* (1990), *supra*, note 426.

1064. For a view of organ scarcity as an arbitrary construct, see George J. Annas, "The Paradoxes of Organ Transplantation" (1988) 78:6 Am. J. Pub. Health 621.

1065. See pages 22-27 above.

The ethico-legal construct is simple in some aspects but complicated in others. It transcends analytic dualisms. The procurement process is not a simple contest between life and death, the living and the dead, hard science and soft sentiment or medicine and death mythology. Society has an evolving commitment to a range of fundamental values and interests. Our commitment to privacy, autonomy, beneficence, religious practices and beliefs, competing moral views on the equal treatment for the dying but not dead potential donor, preserving life and health, human dignity — all help create a sophisticated, textured process through which the body's tissues and organs become available for the therapeutic purposes of the living.[1066] The precise meanings and comparative importance of these values and principles are not always clear and will sometimes be contested. Some of the values are enforced by legal rights — others, by the force of ethical principle. Together, they keep defining and animating the construct.

This ethico-legal construct and the competing values on which it is structured illustrate — at times too bluntly — that while the cherished value of saving life or health determines much, it does not determine all.[1067] If this were otherwise, it might make for more efficient tissue procurement, and a simpler, albeit less rich, human existence. The very wealth of this construct and its sometimes contradictory and entwined values make it integral to our personal and community identities, if only because it reflects and structures thought and choice.

This construct, then, also highlights the helpful but necessarily limited role that the law may play in structuring legal remedies to tissue scarcity. Law is ill-equipped to solve the technical dilemmas of medicine or the philosophical divides of ethics.[1068] Rather, it more typically defines minimal rights and duties in the tissue procurement and transplant process. By doing so, the law helps structure the broad rules under which tissue transfers occur.

The law may tend to give expression to traditional attitudes and values regarding the human body. The traditions and values themselves may, and perhaps should, be called into question by the competing views and values of medical science. If the challenges and questioning spawn confusion and uncertainty, they also present the opportunity to rethink, modify or affirm current rules, practices and values.

It is within this framework — one of rethinking and examining the law, public policies and ethics of conventional and emerging national tissue transfer and replacement regimes — that we propose recommendations to some of the issues explored above. We do so mindful of the important work in this area ongoing by the World Health Organization,[1069] by neighbouring and distant nations and by the provinces across Canada.[1070]

1066. See pages 61-62 and 136-43 above.

1067. See pages 61-62 above.

1068. See pages 34-36 and 61-62 above.

1069. See page 163 above.

1070. See pages 135-36 above.

Our review also persuades us that universal solutions, unfortunately, remain elusive. Indeed, the deep philosophical nature of many of these life-death issues — particularly in the natural tissue transfer regime — indicates that many of the competing interests, values and approaches do not lend themselves to universal solutions. This is not to say that the law cannot offer acceptable options and solutions. Indeed, it can; it may even offer preferred solutions. We believe, however, that these solutions must flow from values long held to be fundamental, and from principles and goals to which Canadian society continually aspires.

II. General Goals and Principles — Towards a Safe and Adequate, Just and Efficient, Tissue Transfer and Supply System

RECOMMENDATION

1. The provision of a safe and adequate, just and efficient, tissue transfer and supply system should be a common national goal of law and public policy.

We are of the view that the diverse public and private players who affect therapeutic tissue transfers in Canada should work towards these common national goals. A commitment to any one of these broad societal goals does not, by itself, dictate the implementation of a specific tissue procurement policy. This is so largely because few, if any, of the values in our ethico-legal construct are absolute or intrinsically determinative. Rather, there is a dynamic, healthy and often conflicting tension between the goals and principles and their underlying values. The goal of achieving an "adequate" supply of tissue, for example, must be tempered and structured by our commitment to safety, human rights and efficiency.

Likewise, the goal of efficiency must be understood in terms of both abiding and contemporary notions of justice in the allocation of scarce health resources.[1071] Efficiency means an effective regional and national transfer system. It also implies a commitment to cost-effective medical interventions. In this sense, society must advance its public and ethical deliberations and its capabilities with regard to economic analysis and medical technology assessment, to evaluate the cost-efficiency and the intergenerational distribution of costs and benefits of, and associated medical learning curves on, transplants and other high technology medical interventions.[1072] Such tools will help define and refine the role of the law.

RECOMMENDATION

2. The development and reform of laws affecting tissue transfer and replacement regimes should be based on principles of

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1071. See pages 32-34 above, and page 190 below.

1072. See pages 32-34 above.

(a) autonomy, inviolability and integrity of the human body;

(b) altruism and encouraged voluntarism;

(c) gratuity and universality;

(d) preserving and protecting life; and

(e) respecting the dying, the dead and their families.

We are persuaded that these five basic principles will advance the goal enunciated in Recommendation 1 and guide the development and reform of laws affecting tissue transfer and replacement regimes. Most of these are engrained in existing law and public policy. Some are extensions or refinements of abiding values or historic approaches in this area, recast in light of modern circumstance. Again, there is a noticeable and healthy tension between some of them. This tension challenges society to balance, and sometimes to choose between, competing principles.

A. Autonomy, Inviolability and Integrity of the Human Body

The *Criminal Code*, the civil law, provincial tissue laws and the *Canadian Charter of Rights and Freedoms* give legal effect to the ethical principle of autonomy. The right to be free from the non-consensual touching of one's physical person protects bodily integrity and privacy and promotes personhood and human dignity. Law, medicine and society owe special protections to, and duties of care and respect for, children, mentally disabled persons, incompetent patients and those otherwise unable to consent to or refuse physical invasions of their bodies.

B. Altruism and Encouraged Voluntarism

Unselfish donation is a laudable public ideal. The public giving of blood, organs and other gifts of life has long been, and should remain, a preferred public policy.[1073] Thus, altruism and voluntarism ought to be nurtured and practised. Increased, creative, educational tissue donation initiatives that are targeted at the public and at health professionals give practical effect to those values.

C. Gratuity and Universality

In this context, the word "gratuity" has special meaning. For nearly a decade, the Canadian Blood Committee has used the gratuity principle in national blood policy to mean that recipients of blood products should not be charged for them.[1074] The general

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1073. See pages 39-41 above.

1074. See *Annual Report of the Canadian Blood Committee to the Provincial-Territorial Conference of Ministers of Health* (1989), *supra*, note 38, appendix A at 3 ("This [the gratuity] principle requires that recipients of blood, components and plasma fractions are not charged for these products provided within the insured health programs of Canada").

commitment of Canadian society to basic notions of justice and its specific commitment to universal access to health services indicate that one's ability to pay should not determine access to scarce therapeutic tissues, organs and derived products. These principles also have implications for donors. The principle that donors should neither gain nor lose financially means that potential donors from all socio-economic levels should have an opportunity to act on their altruism. Hence, insurance coverage[1075] of and payments for donor expenses are legitimate means of ensuring that the less affluent have an equal opportunity to donate. A strong, practical public policy and ethic of giving diminish risks of reducing the human body to a commodity and an object of commerce.

D. Preserving and Protecting Life

Tissue transfer law and public policy are animated by, and should remain premised on, the preservation and protection of human life.

E. Respecting the Dying, the Dead and Their Families

The dying, the dead and the emotional and religious interests of their families are entitled to respect. The legal obligation to accord respect echoes the Hippocratic duty to care. To care is to treat the dying with dignity, to respect the integrity of the dead human form and to comfort the family, honouring and accommodating their needs and wishes as they confront the death of a relative.

III. *Inter Vivos* Transfers — Living Donors

A. Maintaining the Existing Model

RECOMMENDATION

3. The existing model for living donor tissue and organ transfers, which is premised on free and informed consent and a requirement that the risk of harms incurred not be disproportionate to expected benefits in medical interventions, should generally be maintained.

Existing law and public policy on tissue transfers from living donors is generally governed by the requirements that informed consent be obtained and that the risk of harms not be disproportionate to benefits, especially in invasive medical-surgical procedures. This model is generally consistent with, and advances, the above principles.

1075. See text accompanying note 489, *supra*.

B. Donation and Crimes against Bodily Integrity

RECOMMENDATION

4. The *Criminal Code* should be amended by the addition of a provision that excludes, from offences against bodily integrity, those cases of human tissue and organ donation in which the donor's free and informed consent is properly obtained and the risk of harms incurred is not disproportionate to the expected benefits.

Criminal law concerns for protecting the life and bodily integrity of tissue or organ donors parallel the concerns in medical research and human experimentation, where the medical and surgical interventions offer no physical benefit to the subject of the intervention. As in those contexts,[1076] we are of the view that *Criminal Code* provisions defining intentional crimes against bodily integrity[1077] should not apply to tissue and organ donation, *if* (1) informed consent has been obtained from the donor, *and* (2) the risks are not disproportionate to the benefits of the procedure. The risk-benefit ratio should include both physical and psychological factors.[1078] As medical interventions undertaken for therapeutic purposes, such tissue and organ donations would fall under the "medical procedures" exception to the crimes-against-bodily-integrity reforms that the Commission recently proposed in Working Paper 61.[1079]

RECOMMENDATION

5. Tissue procurement from those persons who are incompetent to consent to donation should be regarded as lawful, when there has been a case-by-case determination by an independent third party (for example, court, review board, ombudsman and so forth) to ensure that the following conditions have been met:

(a) the donation of bone marrow and non-regenerative tissue is restricted to donors and recipients in the same family;

(b) all reasonable, potential procurement and medical treatment alternatives have been exhausted;

(c) the procedure does not involve any serious risks to the donor;

(d) the risk of harms incurred is not disproportionate to the expected benefits;

1076. See Working Paper 61, *supra*, note 295; Report 31, *supra*, note 116 at 63; Working Paper 26, *supra*, note 370 at 57-59.

1077. Compare cl. 7(1), (2)(a) and (b) of Report 31, *supra*, note 116 at 61-62, and the maiming/disfigurement assault, battery, provisions of existing *Criminal Code* (ss 244, 265, 266) — all discussed, pages 87-94 above.

1078. See Report 31, *supra*, note 116 at 63; Working Paper 26, *supra*, note 370 at 57-59.

1079. Working Paper 61, *supra*, note 295 at 35-36.

(e) the legal guardian's consent has been obtained; and

(f) where possible, the potential donor's consent has been obtained, and his or her refusal is always to be respected.

Intractable and trying circumstances surround the question of organ donations from minors and mentally disabled individuals. A mature minor who has the capacity to understand and appreciate the risks, benefits and consequences of donating tissues or an organ is similar to an adult in those circumstances.[1080] For potential donors who are incompetent to consent, and thus unable to act self-protectively, such procedures may be consistent with public policy and defensible on grounds of necessity,[1081] in exceptional cases, when specific conditions have been satisfied. First, the principle of inviolability and integrity of the human body and the ethical corollary of doing no harm require that the procedure not involve serious risks to the donor.[1082] As the invasiveness and irreversibility of the procedure increase — from blood to bone marrow to kidney transplants — so do concerns for bodily integrity. Secondly, then, to ensure that incompetent donors are most fully protected from harms, donations from them should only be considered as a last resort — that is, after all reasonable alternative avenues of procurement or alternative medical treatment have been exhausted. Thirdly, the principles of respecting bodily integrity and seeking to preserve life, as reflected in the ethical corollary of beneficence,[1083] suggest that the net benefits of donation may sometimes justify transplants. This would be so when the procedure involves no serious risk to the donor and the incompetent person is capable of appreciating the potential psychological benefits of donation[1084] and the likelihood of life-saving benefits for the recipient. The potential for psychological benefits seems likely to be greatest in intrafamilial donation. Fourthly, the requirements of consent from the guardian and consent or non-objection from the potential donor help ensure that the wishes of the incompetent individual, and of those entitled to speak on his or her behalf, are respected. Such requirements parallel, with some variations, those of the Australian Law Reform Commission[1085] and the Council of Europe[1086] — both of which propose general rules against tissue procurement from incompetent donors, with narrow exceptions governed by strict procedural protections. The Uniform Law Conference of Canada has also recently proposed restrictive requirements.[1087]

1080. See pages 65, 87-95 above.

1081. See *supra*, note 552.

1082. See Beauchamp and Childress discussing non-maleficence, *supra*, note 236 at 120, see also pages 47-48 and 93, above.

1083. See *supra*, note 285 and pages 34, 48-50 and 93 above.

1084. *Ibid.*

1085. See ALRC's recommendation, summarized in note 555, *supra*.

1086. See Council of Europe recommendation, summarized in note 556, *supra*.

1087. See 1989 Uniform Act, *supra*, note 833, ss 6, 7.

IV. Defining Brain Death — Anencephalic Newborn Donors

RECOMMENDATION

6. The "irreversible cessation of all brain functions" standard, proposed by the Commission ten years ago in Report 15, should not be modified to facilitate organ procurement from dying anencephalic infants or other patients who do not meet the whole-brain-death standard.

In Canada, anencephaly results in the death of some fifty newborns per year.[1088] The birth defect is characterized by the absence of a major portion of the upper brain. Those live-born newborns who are afflicted with this tragic birth defect typically die within seventy-two hours after birth. To facilitate organ procurement from live-born anencephalic infants, proposals have been made to consider them as being born dead, brain dead, still-born or otherwise exempt from modern life-death criteria.[1089] For the reasons elaborated above, the Commission is not persuaded that the whole-brain-death definition of death should be amended to facilitate organ procurement from anencephalic newborns. We remain of the view that the legal definition of death should not be determined "by references only or mainly to the practice of organ transplantation."[1090]

V. Post-Mortem Transfers — Deceased Donors

The options for regulating the procurement of therapeutic tissue and organs from the deceased range in a spectrum from the requirement of express consent to the routine procurement of organs regardless of consent or objection. We currently favour retention of the express-consent model for several reasons. First, the technico-ethical construct, described above, casts a necessarily limited role for the law to play in devising remedies to tissue scarcity. Secondly, before recommending reforms that significantly depart from the existing model, we are hopeful that modest reforms aimed at specified ills in the existing system will prove sufficient. Thirdly, this approach seems further advised from a human rights perspective, which cautions government to infringe implicated rights as little as possible in the pursuit of its goals.[1091]

Fourthly, while the Commission is generally committed to efficiency as a national guiding goal, it is also particularly concerned that, for now, it may be imprudent for the law to venture further than removing legal ambiguities and supporting efforts to supply high technology transplants. For legislation to go further and, for example, attempt to

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1088. See text accompanying note 574, *supra*.

1089. See page 97, above.

1090. See page 100, above.

1091. See text accompanying note 893, *supra*.

increase dramatically the numbers of organs might skew important macro-allocation health care priorities. Increased organ supply may further increase the demand for transplants, to the detriment of competing, low technology and demonstrably cost-effective health care and medical procedures that deserve consideration.[1092] Both the Commission and society urgently need more information on which to base more informed decisions of this kind. We therefore urge further research in this area.

Finally, it is the view of many ethicists consulted by the Commission that while alternative models such as presumed consent are ethically acceptable, they are currently unlikely to enjoy wide public support in Canada. If this is accurate, then any significant departures from the current express-consent model should be preceded by broad, persistent educational initiatives that may help phase in models such as general presumed consent, if they prove necessary. The Commission believes that as data on refinements to the express-consent model and data on the scarce allocation of resources become available, society will be better positioned to decide whether it is appropriate to phase in a general presumed-consent approach.

A. Express Consent Required — Opting In

(1) The General Model

RECOMMENDATION

7. (1) The general express-consent model of tissue procurement from deceased donors should be maintained and strengthened, as a preferred model for public policy.

(2) Donors who have declared their wishes to donate should have those wishes legally respected.

This is the generally prevailing model for post-mortem tissue procurement in Canada.[1093] In its favour, it encourages voluntarism and altruism. It also accommodates religious preferences and the surviving family's wishes by enabling families to donate on behalf of the deceased in some circumstances. On the negative side, particular weaknesses in the model result in missed opportunities for donation.[1094] There has also been undue legal uncertainty over whether surviving family members may override the express wishes of a deceased declared donor.

1092. See pages 32-36, above.

1093. See pages 132-33, above.

1094. Compare pages 34-35 and 153-58, above.

(2) Special Cases: Undeclared, Potential Donors and Unclaimed Bodies — Routine Inquiry

RECOMMENDATION

8. (1) Hospitals should implement written organ donation protocols and policies, and consider the adoption of routine-inquiry protocols, to address the problem of undeclared potential donors.

(2) Health and Welfare Canada should undertake and administer a pilot program involving appropriately chosen federal hospitals, for the purpose of implementing and evaluating the impact of routine-inquiry protocols.

(3) Health and Welfare Canada should encourage the participation of non-federal hospitals and the provinces in this pilot program, by making federal funds available to non-federal hospitals prepared to implement and report on routine-inquiry protocols.

Many jurisdictions have encountered significant difficulties with the express-consent approach. Most potential organ donors do not sign tissue donor cards despite consistently high public support in the opinion polls for tissue and organ donation.[1095] This reality results in the all-too-common hospital situation in which a deceased individual, whom a medical team identifies as a potential donor, has given no indication of an intention to donate tissues or organs.[1096]

To help resolve these undeclared donor situations, we support a refinement of the express-consent model, one that has emerged in various nations in recent years, known as "routine inquiry," "recorded consideration" or "required request."[1097] All are premised on existing tissue donation laws that authorize the family of the deceased person to consent to donation on his or her behalf. All essentially require hospitals to (1) adopt protocols to identify both declared donors and undeclared potential donors, and (2) implement protocols such that the families of undeclared potential donors are generally informed of the option or are offered the opportunity of donation. For purposes of our discussion, we use the term "routine inquiry" to describe laws or policies that contain these two features. Variations of the routine-inquiry approach have been adopted in Australia and Great Britain, as well as in federal law, uniform Acts and most state laws in the United States.[1098]

If we acknowledge the merits of the approach, how might it be implemented? Should hospitals or health professionals have a general, or even statutory, duty to identify potential

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1095. See *supra*, note 225. See pages 35-36, 136, 153-58 above.

1096. See pages 34-35 above.

1097. See pages 135-36, 153-59 and 199-200 below.

1098. See *supra*, note 925, and pages 153-59, above.

donors and make inquiries of the family? Since we currently see no need to adopt national tissue procurement legislation, as the United States[1099] has done, the question may be answered by the provinces. But in view of the increasingly national and international dimensions of tissue transfer regimes, the small number of federal hospitals involved in these matters and ongoing provincial law reform deliberations, we offer our analysis of the issue.

Detractors of a statutory duty to inquire generally take the view that such legislation would: (1) be an unwarranted intrusion on professional prerogative and family privacy; (2) address administrative-educative versus legal problems; (3) impose added costs on hospitals and the health care system; and (4) require the performance of duties that might subject violators to sanctions or prosecution.

Proponents of the approach consider that: (1) a prime reason for the scarcity of transplantable tissues is the failure to approach the families of undeclared, potential donors, despite evidence that most would support being given an opportunity to consent in such circumstances, as part of their bereavement process;[1100] (2) imposing an obligation on hospitals would likely result in more tissues and organs for transplantation; and (3) a statutory duty could be drafted so as to permit the exercise of professional discretion and sensitivity to the circumstance. Any such duty should recognize the need for professional discretion not to ask, in the instances where such an inquiry would clearly cause inordinate harm or would otherwise be inappropriate.

In view of these considerations, three particular points persuade us that the above routine-inquiry approaches merit further serious examination in Canada. First, the approaches would seem to offer the opportunity for public and professional education, and a reform specifically targeted at a sensitive and critical area that Canadian analysts consistently identify as a barrier to increased organ donations.[1101] The difficulty seems less in engendering altruism than in giving patients and their families a practical opportunity to act on their good intentions. Secondly, they differ from compulsory procurement and tissue sales options in two important respects: they promote altruism and encourage voluntarism. Thirdly, these approaches seem less likely to provoke legal challenges for infringement on religious freedom, autonomy and privacy. By encouraging voluntarism, and by directly accommodating familial wishes, they appear less likely to infringe basic human and constitutional rights. These considerations suggest that routine inquiry is a preferable remedy to circumstances where the wishes of the donor are undeclared.

A preferable remedy is not a guaranteed remedy, however. There has been some debate as to whether any such statutory duty should be imposed on medical professionals or, more generally, on hospitals. Clearly, surgeons, transplant co-ordinators, neurologists, nurses and hospital chaplains would play pivotal roles in implementing a statutory duty to inquire.

1099. See *supra*, note 995.

1100. See *supra*, note 985.

1101. See pages 35-36, above.

Perhaps many medical professionals already consider a duty to inquire as part of their ethical and professional duty of care. Yet, professional reluctance or resistance may prove to be an influential factor in the success or failure of these approaches. No individual should be compelled to "request donation." But it is also not in the public interest for organs to be wasted because consent was not considered by donors or their families at the critical moment.

Practical considerations may help alleviate these concerns. Since many undeclared, potential donors die in a hospital, it would seem advisable that any legal duty to ask should be imposed on the institution, as the Canadian Bar Association has suggested (see appendix A). Imposing the duty on the hospital might also allow it to be administratively creative in delegating the duty to ask to professionals who would act sensitively, efficiently and in a cost-effective manner.

Health and Welfare Canada might help evaluate any impact that hospital organ donor protocols and routine-inquiry approaches have on undeclared donor circumstances, by designing and co-ordinating a methodologically sound pilot program involving appropriate federal hospitals. By making federal funds available to hospitals prepared to undertake pilot projects implementing and reporting on routine inquiry, Health and Welfare Canada may also encourage the participation of non-federal hospitals. The data provided by participating hospitals may help society to assess the benefits of refinements to the express-consent model of post-mortem organ donation.

In this vein, the following protocol for the routine-inquiry model may prove helpful in addressing the problem of undeclared potential donors. It is a variation of an approach recommended by the Australian Law Reform Commission and adopted in most Australian states.[1102]

> (1) Hospitals should implement written tissue and organ donation protocols and procedures to identify potential donors. The procedures should include professional education and training.
>
> (2) Hospitals with such protocols should have a general authority to procure tissue and organs from undeclared potential donors, depending on the discharge of two duties. Diligent efforts, made in good faith, should be undertaken
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> > (*a*) to determine the existence of documentary evidence of the deceased's intentions to donate,
>
> and, if none are found,
>
> > (*b*) to contact the family, giving family members the opportunity to donate, by informing them of the donation option. Non-consent of the family should be legally binding. Efforts to identify and contact the family, directly and through public authorities, should continue for a reasonable period of time (for example, forty-eight hours or otherwise taking into account the reasonable survival time of the

1102. See pages 158-59, above.

tissue). Those responsible for the diagnosis of brain death or the determination of donor suitability should not be involved in the above efforts.

(3) Where diligent efforts, made in good faith, fail to identify or contact the surviving family, no procurement should take place.

Some points should be noted about item (3) of the above model protocol, which addresses procurement from undeclared potential donors who have no immediately ascertainable family members. The suggestion in the model that no procurement should proceed in such circumstances is based on an express-consent rationale. Some analysts and jurisdictions, however, have urged or adopted limited presumed-consent rationales in such instances. Australian and American legislation authorizes tissue and organ procurement in limited circumstances from undeclared potential donors having no ascertainable family members.[1103] The Uniform Law Conference of Canada's 1989 *Uniform Human Tissue Donation Act* also appears to adopt a limited presumed-consent principle for tissue procurement from such donors in medical examiner cases.[1104] This has had historic precedent in Canada since the nineteenth century, when unclaimed bodies were first made available to medical schools under provincial anatomy laws.[1105]

B. Presumed Consent — Opting Out

Presumed-consent theory maintains that society may reasonably presume that one consents to post-mortem tissue donation unless there is evidence of objection. As with express consent, presumed consent focuses on the deceased's intentions to give, and is thus more accommodating of altruism than is compulsory procurement. The presumption of consent is thought to be reasonable on the basis of community altruism, and is further necessitated by the principle of saving life that may be advanced by potential increases in available organs and tissues. The approach is also thought to avoid exacerbating familial grief that may result from insensitive requests for organ donation.

Several considerations would, however, seem to argue against immediate, general implementation of presumed consent. First, evidence from France and other European countries that have adopted this approach suggests that it may not always result in more organs.[1106] Secondly, the theories and purposes behind presumed consent may be frustrated by the practical difficulties of determining whether the deceased has actually opted out of the presumed-consent scheme, and by the clinical and psychological realities of dealing with death and the surviving family.[1107] Competing presumed-consent theories in Western Europe have yielded laws that differ with regard to the legal role of the family in conveying the deceased's intentions.[1108] The letter of the law notwithstanding, the actual clinical practice in most cases is to involve the family. This seems to call into question

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1103. See chap. 4, above.

1104. See *supra*, note 837.

1105. See pages 2-3 and 127-29 above.

1106. See pages 147-53, above.

1107. *Ibid.*

1108. See pages 147-53 and 165, above.

the utility of a strict presumed-consent approach. Thirdly, some presumed-consent statutes in the United States have been challenged as violating fundamental human rights.[1109] Finally, the concept of presumed consent may decrease communication within the doctor-patient-family relationship at a time when dialogue and understanding need to be especially nurtured and encouraged. If such potential ills may be avoided by other procurement options that yield substantially equivalent therapeutic supplies, then the presumed-consent option seems less preferred.[1110] Such considerations persuade us that the currently limited application of presumed-consent laws[1111] in Canada should not be extended. We expect that, as data on the effects of routine-inquiry approaches becomes available, the relative value of a general presumed-consent approach will be better understood.

C. No Consent Required — Routine, Compulsory Procurement

Under different views of autonomy, routinely procuring tissues and organs from deceased donors, regardless of the intentions they might have expressed while alive, may violate the ethical principles of autonomy of the living potential donor and respect for the dead. The approach also seems more likely to violate religious beliefs and practices, and exclude legitimate familial considerations from procurement policy. Routine, compulsory procurement would also reverse existing post-mortem tissue procurement policy in Canada. The Commission does not favour this option, as is made clear in our endorsement of the express-consent model of post-mortem procurement.[1112]

D. Respecting the Dead

RECOMMENDATION

9. (1) Section 182 of the *Criminal Code* should be replaced by a provision making it a crime to abuse a human corpse or human remains.

(2) The Commission's Report 31 should be amended by incorporating into the proposed Crimes against Public Order (chapter 22) the following subsection:

> **Abuse of Corpse. Everyone commits a crime who purposely or recklessly abuses a human corpse or human remains.**

The duty to respect the dead body is a duty not to violate its intrinsic dignity and humanity. It includes accommodating the expectations and the moral and religious

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1109. See pages 138-42 above.

1110. See text accompanying note 893, *supra*.

1111. See text accompanying notes 845 to 848, *supra*.

1112. Accord MLRC, *supra*, note 157 at 30-31.

sentiments of the family. Mistreating the dead may, in the extreme, offend moral sentiments commonly held by society at large. Some non-consensual medical use of the recently deceased, or of a brain-dead, mechanically sustained cadaver-patient, may not disfigure, mutilate or otherwise significantly invade the physical integrity of the dead body. Yet, the practice may still offend the next of kin by breaching the relationship of trust on which doctors, patients and their families and hospitals so greatly depend.[1113]

In the criminal law context, we are concerned that the century-old *Criminal Code* provision on crimes against the dead, section 182, be coherent and clear. That section addresses both burial duties and the mistreatment of dead bodies. In Report 31, the Commission generally describes the provision as archaic. Indeed, since provincial laws now regulate burial matters, the *Criminal Code* burial provision, paragraph 182(*a*), would no longer seem necessary.[1114]

The situation regarding paragraph 182(*b*), the *Code* provision on mistreating the dead, differs. Most provincial burial laws are limited to the policing of conduct that relates to cemeteries. Most criminal sexual assault offences contemplate a living victim. Thus, neither they nor current or proposed criminal offences clearly or sufficiently cover unlawful and intentional mutilation of the dead human body, sexual interference with it or other general unlawful abuse of it. In our view, such conduct visits universal dignitary harms on both the dead and society as crimes against humanity. Both older and revised criminal codes, and provisions in force in nations such as France, Australia, the United States and New Zealand, express societal condemnation of such conduct through penal sanctions.[1115] The language in the proposed offence is broad enough to encompass a range of offences, and is based on the United States *Model Penal Code* provision.[1116] Under chapter 3(13) of Report 31, which immunizes from criminal liability those acting under legal authority, the offence would not apply to lawful interventions performed on the dead, such as autopsies, organ transplants and funeral preparations.

VI. General Considerations

A. The Safety of Tissue Replacement Technology

RECOMMENDATION

10. (1) Legislation should clearly establish the inclusion of all human therapeutic tissue replacement technologies within the "safety" ambit of the federal *Food and Drugs Act*, to subject them to minimum, uniform national safety standards.

1113. See pages 113-17 above.

1114. See pages 108-13 above, especially note 698, *supra*.

1115. See *ibid.*, especially *supra*, notes 676, 696.

1116. See pages 108-13 above, especially notes 692, 696, *supra*.

(2) Accordingly, the *Food and Drugs Act* should be amended to include a new Part for the regulation of human therapeutic tissue replacement technologies, broadly defined.

The genius of the modern biomedical and biotechnological sciences has begun to blur the lines between some of the human therapeutic tissues, bodily substances and tissue products of the regimes. As the trend towards processed, biosynthetic, bioprosthetic tissues accelerates, ambiguities in laws governing the regimes become more pronounced. Under existing law, it may not be clear whether some tissues, bodily substances and biosynthetic tissue replacement technologies — such as cryolathed and implanted eye lenses, bioprosthetic heart valves, processed, preserved bone marrow or semen — are subject to the same minimal, national safety standards as are other replacement technologies for tissues such as blood plasma and intraocular lenses.[1117] Since the *Food and Drugs Act* also affects products imported into Canada, clear inclusion of therapeutic tissue replacement technologies in the FDA would enhance national and international protection.[1118]

The proposed legislative amendment would remove these ambiguities in the law. An alternative to the recommendation would involve amending the FDA to provide Health and Welfare Canada with authority to identify, by regulation, a tissue as a biologic drug, medical device or implant. Because this alternative would essentially involve fitting a tissue replacement technology into existing regulatory regimes, it may not provide sufficient statutory breadth to regulate emerging and forthcoming technologies. The Commission, therefore, favours the addition of a Part governing tissue replacement technology to the FDA, to provide Health and Welfare Canada with broad, express authority parallel to the existing authority to regulate drugs, medical devices and cosmetics.

B. Regulating or Prohibiting Sales

RECOMMENDATION

11. (1) The purchase or sale of human bodies, organs and other non-regenerative tissue should be made a *Criminal Code* offence.

(2) In defining the scope of the sales prohibition, the legislative provision should exclude from the definition of "sale" reasonable payments for travel or lodging expenses and lost wages incurred by the donor as well as reasonable payments associated with procurement, transport, processing, preservation and implantation of tissue.

Two ethical rationales and two avenues of control are typically offered in arguments against the sale of tissues. The "formalist" views sales as a *prima facie* moral wrong.

1117. See pages 117-23 above.

1118. See *ibid.*, especially *supra*, note 761.

The "consequentialist" may reject sales on the basis of the balance between good or harmful consequences. Both views might lead to a sales prohibition. The consequentialist position, however, admits of the possibility of authorizing sales. Indeed, a true consequentialist will opt for a non-prohibition when the likely benefits of sales outweigh likely harms, or when the likelihood of potential harms is judged insufficient to warrant legal prohibition. For example, provincial gift tissue laws enacted over the last two decades have tended to adopt a consequentialist approach, opting to prohibit the sale of non-regenerative tissue.[1119]

From both formalist and consequentialist perspectives, the purchase and sale of the human body, organs and non-regenerative tissue may be prohibited. From the first perspective, the sale of the dead violates a commonly shared morality regarding respect for the dead and the respect owed to a deceased human being. This view has been the historical basis of section 182 of the *Criminal Code*. The sale of a living human body violates the intrinsic and inalienable right of human beings not to be the subject of barter. This view is currently expressed in provincial laws on adoption. The sale of human organs, too, violates human dignity, as expressed in the often heard concern about commodification.

Payments for human organs and bodies also provoke legitimate consequentialist concerns about, such as monetary incentives that invite sellers to compromise health and safety by taking undue physical risk; or, the allocation of scarce tissue on the basis of the highest bidder, which risks skewing more important allocative criteria such as medical need.[1120] While these formalist and consequentialist concerns may inhere in the sale of regenerative tissue and substances, they would seem most concentrated and compelling with respect to bodies, organs and non-regenerative tissue.[1121]

These arguments bear directly on whether organ sales should be expressly prohibited as a *Criminal Code* offence. To evaluate the merits of creating a criminal offence, the Commission has established four criteria.[1122] In the present context, they frame the following questions: Do organ sales (1) seriously harm others, or (2) seriously contravene fundamental values? If so, (3) would enforcement measures against such acts infringe fundamental values, and (4) would the criminal law significantly contribute to remedying the problem?

Applying the above-mentioned questions to organ sales reveals that the issue of whether or not to create a criminal offence hinges largely on whether the criminal law can make a significant contribution to curing the ills associated with sales. In terms of serious

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1119. See pages 130-36, especially *supra*, notes 843, 856.

1120. See pages 82-83, above.

1121. While medical technology has apparently begun to blur the once clear line between some regenerative and non-regenerative tissues and organs, the distinction still proves helpful in categorizing the general nature of physical risks, medical invasiveness and irreversibility, which accompany donation and transplant. See *supra*, note 85 and pages 19-20, 47 and 82, above.

1122. See Report 3, *supra*, note 730 at 33. See also LRC, *Crimes against the Foetus*, Working Paper 58 (Ottawa: The Commission, 1989) at 32.

harms to others, money may induce individuals to take undue physical risks, induce sellers — who fear that payment would not be made for a diseased or otherwise defective tissue — not to disclose medical information about a transmissible or genetic disease that may harm the recipient; in the extreme, the high price for organs may invite the taking of human life.[1123] In terms of fundamental values, if altruism is considered fundamental, sales may erode its gift-of-life ethic. Sales arguably violate human dignity, by exploiting economic and medical desperation, and by commodifying the human body and its parts — all of which colours how we think about and value our bodies and selves.[1124] Enforcement of a sales offence would not infringe personal liberty or privacy, unless a broad construction of its terms is thought to include a right to alienate, for profit, vital parts of the human body. Enforcement might have a disproportionate impact on persons who are economically disadvantaged and who might seek to enhance their economic status by sales. But enforcement seems unlikely to undermine the value of saving life, because more ethically acceptable alternatives may increase the supply of human therapeutic tissue.

Will a *Criminal Code* offence make a significant contribution to resolving the problems associated with organ sales? Some may argue that it will not, on the grounds that the criminal law is too blunt an instrument for such ills. They may further point out either that regulation is a more appropriate means of curbing potential ills or that sales are already prohibited under most provincial Acts. Others may argue yes, on the grounds that the moral harms to the fundamental values of human dignity, altruism and personhood, the potential for physical harms to the individual and the need for protection of the individual combine to justify invoking the full deterrent effect and stigma of the criminal law. In this view, the offence would establish minimum uniform criminal liability across Canada for increasing interprovincial tissue transfers, and have effect in provinces without, with limited or with dysfunctional sales prohibitions. In advancing the sales offence recommendation, we are mindful of the important legislative consideration the provinces are giving to the recently proposed 1989 *Uniform Human Tissue Donation Act*.[1125] In these nation-wide deliberations on the reform of tissue transfer laws, serious scrutiny ought to be given to the precise scope and definition of sales prohibitions in proposed and existing law, as well as the comparative approaches under recent American, British, Australian and European legislation.[1126]

Finally, a sales offence may prove responsive to transnational developments.[1127] Heightened concerns on north-south and east-west organ sales in the international community have recently been reported or confirmed.[1128] As such, a *Criminal Code* offence provision would respond to the recent and continuing international and World Health Organization calls, in which Canada has assumed a leadership role, for national initiatives to curb organ sales.[1129]

1123. See Roughead, *supra*, note 664 and accompanying text.

1124. See pages 54-61 and 78-86, above.

1125. See text accompanying notes 853-857, *supra*.

1126. See chap. 4, above.

1127. See pages 162-63, above.

1128. *Ibid.*

1129. See pages 162-64, above.

Hence, our recommendation implements the principles of gratuity and the inviolability of the human body. It rejects proposals to develop markets in organs as being premature and directly contrary to altruism. The shortcomings of altruism need not necessitate society's embracing commercialism. Increased tissue donation, to save and promote human life, may be advanced by mechanisms more consistent with Canadian public policy. To ensure that payments for legitimate transfer expenses would not be considered sales, our recommendation excludes from the sales definition payments for reasonable transport, processing, preservation and like expenses. This further ensures that coverage or payment of reasonable donor expenses is not penalized. Thus, donors would neither gain nor lose financially for exercising altruism.[1130]

C. Bodily Property and Theft

RECOMMENDATION

12. Human remains or bodily substances that are in one's lawful possession or that have been lawfully procured and transformed by skill and labour into such entities as human anatomical specimens, processed and preserved tissue or museum artifacts should be considered proprietary objects that fall within criminal law protections against theft.

Our research reveals a notable ambiguity which has survived the century-old *Criminal Code* provision on the mistreatment of corpses. The historic basis of the offence arguably suggests that human remains which have been lawfully procured, and transformed by dint of skill and labour into museum mummies, human anatomical specimens or similarly processed and preserved human tissue, may not be protected from theft by the criminal law because of the common law reluctance to recognize property in a corpse.[1131] This reluctance suggests that one may be prosecuted for theft of burial wraps but not of the body; for theft of the wire holding a laboratory skeleton together but not of the skeleton itself; and for theft of a capsule containing tissue or bodily substances but not of the substance itself.[1132] This position has been critiqued by the authorities.[1133] Today, it seems both anomalous and contrary to the basic values of criminal law and broader contemporary concepts of property. Modern legal analysis no longer automatically equates property with commerce. We are, therefore, of the opinion that the values of the criminal law are better served by removing this ancient ambiguity.

1130. See pages 84-86, above.

1131. See pages 65-70, above, especially *supra*, note 384, and pages 108-13 above, especially *supra*, note 701.

1132. *Ibid.*

1133. *Ibid.*, especially *supra*, note 701.

RECOMMENDATION

13. (1) Where health providers, hospitals or researchers develop a commercial interest in a patient's tissues or cellular matter, or where the development of any such interest is reasonably foreseeable, the health providers, hospitals or researchers should be obliged to disclose the interest to the patient.

(2) Where it becomes reasonably clear that the health provider with the commercial interest may compromise his or her duty to exercise independent professional judgment strictly on behalf of the patient, the health provider should be obliged to transfer care of the patient.

(3) Following the health provider's disclosure to the patient of any such commercial interest, the patient should be given the opportunity to decline further treatment and involvement, and if he or she so declines, the health provider should be obliged to transfer care of the patient.

It is currently unclear whether statutory reform of the *Patent Act*, more explicit medical research guidelines or a simple extension of common law principles will answer some of the new riddles posed by biotechnological progress.[1134] How does society protect the bodily integrity, autonomy and dignity of human tissue sources, such as patients, while providing proper incentives and protections for the creative genius of biotechnologists who develop potentially lucrative therapeutic fruits that benefit the public? Today's progress would seem to make the legal maxim "The law cares not for trifles" no longer applicable to excised tissues or secreted bodily substances long regarded as valueless and abandoned.[1135]

Some have argued that legal recognition of limited property interests — as distinct from commercial interests — will protect patients against non-consensual bodily invasions or the non-consensual commercial development or use of excised or deposited tissue.[1136] It remains to be seen whether the recognition of such interests will help clarify the legal rights of donors and the corresponding duties of medical professionals *vis-à-vis* human substances.

In the meantime, traditional medico-legal principles may offer guidance. If a physician, hospital or researcher has an interest in a patient's cells or tissues, or if the development of such an interest may be reasonably foreseen, disclosure of the interest would seem to be required under informed-consent principles. The foreseeability test here is an objective standard. The disclosure requirement is buttressed by the physician's fiduciary duty: that of loyalty, trust and good faith to the patient. If the physician has a commercial or other interest potentially in conflict with the duty to exercise independent professional judgment

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1134. See pages 31-32, 73-77 and 123, above.

1135. See page 75, above.

1136. See pages 65-78, above.

and act strictly on behalf of the patient, the general rule should require disclosure to the patient and a full explanation of the conflict. The patient would then have an opportunity to consent to continued treatment or to participation. If the patient were to decline further involvement, or if it were reasonably apparent that the physician's conflict had compromised the ability to provide disinterested, professional treatment, the physician would have an obligation to transfer care of the patient. Surveillance by hospital research and ethics committees may also reduce the potential for abuse.

While the foregoing principles may curb the potential for disputes between the sources and the developers of commercial tissue interests, they may not do justice to the complexity of the competing interests and issues involved. Thus, as we specify below, further research is required in this dynamic area.

D. Tax Incentives?

RECOMMENDATION

14. The *Income Tax Act* should not be currently amended to permit credits or deductions for tissue or organ donation.

Should the charitable-gift concept of donation be given practical, monetary effect through the tax law? In foreign jurisdictions, legislative proposals have been introduced, but to our knowledge never enacted, to provide tax deductions or credits for human therapeutic tissue and organ donation.[1137] While it is unclear whether such incentives would increase supplies, it is likely that charitable deductions would benefit higher-income taxpayers the most. In the context of the prevailing tissue transfer regimes, such tax treatment may also tend to monetize the value of natural tissues and lend the impression that they may indeed be priced[1138] like ordinary commodities — all at the risk of undermining the altruistic basis on which this public regime depends.

VII. Questions Warranting Further Research

A number of related matters of national interest warrant further attention in the expanding domain of tissue transfer and tissue replacement technology. More study is needed on: the allocation of scarce resources and transplant waiting lists; procuring, transforming and commercializing human cells and tissues; fetal tissue transplants; international transfers; and the ethical status of neomorts.

1137. See *supra*, note 800.

1138. See Kant, *supra*, note 352 and accompanying quotation in the text.

A. Allocating Scarce Resources[1139]

What is the optimal societal investment in organ and tissue transplants or primary and preventive care? To advance ethical and public deliberation on such macro-allocation questions, further study of the cost-effectiveness of transplant technologies is warranted, as part of a global societal effort to subject high technology medicine to continuing critical assessment. Indeed, it may be time to include cost-effectiveness as a national criterion of the *Canada Health Act* commitment to provide "medically necessary" health services to Canadians.[1140] The federal-provincial initiative that recently created the Canadian Co-ordinating Office for Health Technology Assessment is a welcome, commendable step in this direction. Tissue and organ replacement technology would seem an apt subject for the early attention of that Office. Society might benefit invaluably from a national resource that provides competent, unbiased information on the benefits and risks, as well as the biological, economic, legal and ethical effects, of new technologies.

Investing resources in tissue replacement technology often begets challenging micro-allocation choices as well. What are the medical, ethical and legal bases for allocating organs and priorities to persons on transplant waiting lists? Whether the bases include medical need, first-come first-served allocation, lottery, age or social standing, they should be examined to understand whether they comport with basic notions of fairness. Viewing donated tissues and organs as a precious national resource may heighten the duty to allocate them equitably and efficiently. It may also suggest a good Samaritan ethic of sharing transplant resources with nations lacking them. Because these allocation issues implicate fundamental values and pressing questions of distributive justice, they merit the immediate and continuing attention of government, professional and university groups and the public.

B. Procuring, Transforming and Commercializing Human Cells and Tissue

Who has, or should have, commercial and patent rights to therapeutic products that are biotechnologically developed from human cells and tissues? Existing law does not resolve or clearly answer this question for patients, research subjects, physician researchers or the biotechnology industry. Such uncertainty may increase the potential for disputes. A multidisciplinary examination of the issues and options should yield more legal and ethical certainty.

C. Fetal Tissue Transplants

Preliminary studies suggest that fetal tissue may be useful in the treatment of illnesses such as Parkinson's disease, a devastating neurological disorder. Under what circumstances,

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1139. See pages 32-34, above.

1140. See A. Leaf, "Cost Effectiveness as a Criterion for Medicare Coverage" (1989) 321:13 N. Engl. J. Med. 898.

if any, should it be ethically and legally permissible to use fetal cells from voluntarily and involuntarily terminated pregnancies for therapeutic transplants? Who should decide? Does it matter that there is historical precedent for such use in the development of vaccines?

D. International Tissue Transfers

To what extent should there be regional global systems for the international transfer of tissue? While the medical care systems of Canada and the United States are distinct, they regularly share medical resources, including organs and tissues. As national tissue- and organ-sharing and allocation systems develop, increased attention should be devoted to efficient and fair tissue sharing in North America. If it is sometimes more medically efficient to send organs north-south rather than east-west, how should the medical considerations weigh against considerations of national self-sufficiency? Should we adopt agreements to govern safety concerns and the exchange of therapeutic substances, as some European countries have done?

E. Neomorts

What is the ethical status of the brain-dead, mechanically sustained, cadaver-patient? Should hospital protocols governing patients apply until mechanical support is withdrawn and the cadaver resembles a traditional corpse? Such protocols may or may not resolve the ethics of maintaining brain-dead pregnant women until they give birth, or of conducting research on the neomort or using it for medical training.[1141] The ethical status of these deceased patients needs to be clarified.

1141. See pages 113-17, above.

Summary of Recommendations

1. The provision of a safe and adequate, just and efficient, tissue transfer and supply system should be a common national goal of law and public policy.

2. The development and reform of laws affecting tissue transfer and replacement regimes should be based on principles of

(a) autonomy, inviolability and integrity of the human body;

(b) altruism and encouraged voluntarism;

(c) gratuity and universality;

(d) preserving and protecting life; and

(e) respecting the dying, the dead and their families.

3. The existing model for living donor tissue and organ transfers, which is premised on free and informed consent and a requirement that the risk of harms incurred not be disproportionate to expected benefits in medical interventions, should generally be maintained.

4. The *Criminal Code* should be amended by the addition of a provision that excludes, from offences against bodily integrity, those cases of human tissue and organ donation in which the donor's free and informed consent is properly obtained and the risk of harms incurred is not disproportionate to the expected benefits.

5. Tissue procurement from those persons who are incompetent to consent to donation should be regarded as lawful, when there has been a case-by-case determination by an independent third party (for example, court, review board, ombudsman and so forth) to ensure that the following conditions have been met:

(a) the donation of bone marrow and non-regenerative tissue is restricted to donors and recipients in the same family;

(b) all reasonable, potential procurement and medical treatment alternatives have been exhausted;

(c) the procedure does not involve any serious risks to the donor;

(d) the risk of harms incurred is not disproportionate to the expected benefits;

(e) the legal guardian's consent has been obtained; and

(f) where possible, the potential donor's consent has been obtained, and his or her refusal is always to be respected.

6. The "irreversible cessation of all brain functions" standard, proposed by the Commission ten years ago in Report 15, should not be modified to facilitate organ procurement from dying anencephalic infants or other patients who do not meet the whole-brain-death standard.

7. (1) The general express-consent model of tissue procurement from deceased donors should be maintained and strengthened, as a preferred model for public policy.

(2) Donors who have declared their wishes to donate should have those wishes legally respected.

8. (1) Hospitals should implement written organ donation protocols and policies, and consider the adoption of routine-inquiry protocols, to address the problem of undeclared potential donors.

(2) Health and Welfare Canada should undertake and administer a pilot program involving appropriately chosen federal hospitals, for the purpose of implementing and evaluating the impact of routine-inquiry protocols.

(3) Health and Welfare Canada should encourage the participation of non-federal hospitals and the provinces in this pilot program, by making federal funds available to non-federal hospitals prepared to implement and report on routine-inquiry protocols.

9. (1) Section 182 of the *Criminal Code* should be replaced by a provision making it a crime to abuse a human corpse or human remains.

(2) The Commission's Report 31 should be amended by incorporating into the proposed Crimes against Public Order (chapter 22) the following subsection:

Abuse of Corpse. Everyone commits a crime who purposely or recklessly abuses a human corpse or human remains.

10. (1) Legislation should clearly establish the inclusion of all human therapeutic tissue replacement technologies within the "safety" ambit of the federal *Food and Drugs Act*, to subject them to minimum, uniform national safety standards.

(2) Accordingly, the *Food and Drugs Act* should be amended to include a new Part for the regulation of human therapeutic tissue replacement technologies, broadly defined.

11. (1) The purchase or sale of human bodies, organs and other non-regenerative tissue should be made a *Criminal Code* offence.

(2) In defining the scope of the sales prohibition, the legislative provision should exclude from the definition of "sale" reasonable payments for travel or lodging expenses and lost wages incurred by the donor as well as reasonable payments associated with procurement, transport, processing, preservation and implantation of tissue.

12. Human remains or bodily substances that are in one's lawful possession or that have been lawfully procured and transformed by skill and labour into such entities as human anatomical specimens, processed and preserved tissue or museum artifacts should be considered proprietary objects that fall within criminal law protections against theft.

13. (1) Where health providers, hospitals or researchers develop a commercial interest in a patient's tissues or cellular matter, or where the development of any such interest is reasonably foreseeable, the health providers, hospitals or researchers should be obliged to disclose the interest to the patient.

(2) Where it becomes reasonably clear that the health provider with the commercial interest may compromise his or her duty to exercise independent professional judgment strictly on behalf of the patient, the health provider should be obliged to transfer care of the patient.

(3) Following the health provider's disclosure to the patient of any such commercial interest, the patient should be given the opportunity to decline further treatment and involvement, and if he or she so declines, the health provider should be obliged to transfer care of the patient.

14. The *Income Tax Act* should not be currently amended to permit credits or deductions for tissue or organ donation.

Glossary of Medical Terms

ALBUMIN. See BLOOD PRODUCTS.

ANEMIA. A deficiency in the red blood cells that prevents sufficient oxygen from being carried to tissues and organs. A major complication of chronic kidney failure, the condition often afflicts kidney transplant and dialysis patients, and is characterized by fatigue, lethargy and loss of appetite. It is conventionally treated by iron supplements or, in more extreme cases, by blood transfusions.

ANENCEPHALY. A lethal birth defect characterized by the absence of a major portion of the brain, skull and scalp.

BIOLOGIC. A special category of drug products derived from human and animal tissues.

BIOPROSTHETIC/BIOSYNTHETIC. Terms used to describe a therapeutic agent derived partially from natural tissue and partially from synthetic, mechanical or artificial processes.

BLOOD PRODUCTS. Therapeutic products derived from the red blood cells and plasma components of whole blood.

- ALBUMIN. A derivative manufactured from human plasma and used to treat burns, shock and other conditions.
- FACTOR VIII. An antihemophilic, blood-clotting factor manufactured from human plasma.
- PLASMA. The liquid component of blood in which red blood cells, white blood cells and platelets are suspended. Plasma constitutes some 55%, and the cellular elements some 45%, of human blood.

CELL LINE. An indefinitely replicating, cellular growth derived from the *in vitro* cultivation of living cells.

DEOXYRIBONUCLEIC ACID (DNA). The organic molecule that contains genetic information in virtually all living cells.

DIALYSIS. See KIDNEY DIALYSIS.

DURA MATER. A tough membrane that covers and protects the brain. In the transplant field, processed dura mater is used for reconstructive brain surgery.

EPIKERATOPHAKIA (EPI). Surgical implantation of procured, processed, and preserved human eye tissue, which has been lathed (sculptured) to individual patient specification. The resulting implant is sometimes referred to as the living contact lens.

ERYTHROPOIETIN (EPO). A protein made in the kidneys that stimulates the production of red blood cells. Recombinant DNA EPO has recently become available as a drug to treat chronic anemia in kidney transplant and dialysis patients.

FACTOR VIII. See BLOOD PRODUCTS.

HUMAN GROWTH HORMONE (HGH). Produced in the pituitary gland, HGH helps regulate the growth of children. Traditionally derived from cadaveric pituitary glands, HGH drugs today are derived using rDNA technology.

INTRAOCULAR LENS. A (synthetic) lens implanted in the eye to affect its structure and function, and to replace the natural lens of the eye.

KERATOPLASTY. Surgical replacement of dysfunctional corneas, the outer transparent window covering the eye.

KIDNEY DIALYSIS. A treatment process through which impurities and toxic substances are filtered and removed from the blood by a dialyser, a machine commonly referred to as the artificial kidney.

PLASMA. See BLOOD PRODUCTS.

RECOMBINANT DNA (rDNA). Also referred to as gene cloning and genetic engineering, the process involves transferring portions of DNA from one cell into another, so that as the recipient cell grows it expresses and replicates the genetic make-up of the donor cell. Recombinant DNA drugs derived from human and animal tissue have emerged as important products of the biotechnology revolution.

APPENDIX A

Selected Medical, Ethical and Legal Pronouncements

(1) Canadian Medical Association (CMA)

(a) CMA Code of Ethics (Statement on Transplantation)[1]

An Ethical Physician ...

20. may, when death of the brain has occurred, support cellular life in the body when some parts of the body might be used to prolong the life or improve the health of others;

21. will recognize his responsibility to a donor of organs to be transplanted and will give to the donor or the donor's relatives full disclosure of the intent and purpose of the procedure; in the case of a living donor, the physician will also explain the risks of the procedure;

22. will refrain from determining the time of death of the donor patient if there is a possibility of being involved as a participant in the transplant procedure, or when his/her association with the proposed recipient might improperly influence professional judgement;

23. may treat the transplant recipient subsequent to the transplant procedure in spite of having determined the time of death of the donor; ...

(b) CMA Policy Summary: Organ Donation[2]

Organ transplantation is now a recognized form of treatment. No shortage of potential organ donors exists, and public opinion toward organ donation is generally favourable. The demand, however, for donor organs has outstripped the supply. A major barrier to organ donation has been the incomplete commitment of the medical profession to identify potential donors and seek consent from the nearest relatives. To help rectify this, the CMA supports the concept of "recorded consideration", which means that hospital staff are routinely required to consider the suitability of a dying or "brain-dead" patient for organ donation in time for donation to occur. To present the medical profession as a role model, the association is conducting an organ donor recruiting campaign to provide all physicians in Canada and their families with the opportunity to sign an organ donor consent card.

(2) Canadian Nurses Association

Organ Transplantation Position Statement[3]

The Canadian Nurses Association recognizes that the transplantation of organs and tissues has evolved to the state of being a replacement treatment for organ failure. Further, CNA recognizes that successful

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1. Canadian Medical Association, *Code of Ethics* (Ottawa: The Association, 1990).

2. (1987) 136:6 C.M.A.J. 752A.

3. "Statement on the Role of Nurses in Organ and Tissue Donation, Retrieval, and Transplantation" (1987) *Position Statements Canadian Nurses' Association.*

transplantation can lead to improved quality of life, increased lifespan, and decreases in illness care costs. Therefore, CNA supports the concept of organ and tissue donation, retrieval and transplantation programs recognizing that the major problem in the establishment of successful programs is the procurement of donor organs.

(3) Canadian Bar Association

Resolution to Amend the Human Tissue Gift Act(s)[4]

WHEREAS an important part of the Canadian health care system is the transplant services (which are now reliable, effective, and available across the country);

AND WHEREAS the staff of hospitals may fail to ask the deceased person's representative to consent to organ donation, even when the staff is aware of persons who will die if the donation is not made;

AND WHEREAS surveys indicate that Canadians as a whole strongly support transplant programs, but only a few Canadians make a direction that their organs be donated;

AND WHEREAS 85-90 per cent of families and/or representatives who are asked to consent to an organ donation of a deceased relative agree to the donation and families and/or representatives of deceased persons have often expressed dismay that they were not provided the opportunity to consent to such an organ donation;

AND WHEREAS families and/or representatives of deceased persons who are provided the opportunity to consent to such a donation, and who consent, report that this donation helped them in their bereavement, both shortly after the death, and in the months and years thereafter;

BE IT RESOLVED THAT The Canadian Bar Association urge the Federal, Provincial and Territorial Governments to amend or enact legislation which would impose statutory obligations on hospital staff to request permission or cause permission to be requested from the deceased person's representative to use any or all of the tissues of the deceased person.

(4) World Medical Association

Declaration of Human Organ Transplantation

39th World Medical Assembly: Madrid, October 1987[5]

The World Medical Association recommends the following guidelines for the guidance of physicians engaged in the transplantation of human organs.

1. The primary concern of physicians must at all times be the health of their patients. The concern and allegiance must be preserved in all medical procedures, including those which involve the transplantation of an organ from one person to another. Both donor and recipient are patients and care must, therefore, be taken to protect the rights of both. No physician may therefore assume a responsibility in organ transplantation unless the rights of both donor and recipient are protected.

2. A potential organ transplant offers no justification for a relaxation of the usual standard of medical care. The same standard of care should apply whether the patient is a potential donor or not.

3. When an organ is to be transplanted from a donor after the donor's death, the death of the donor shall have been determined independently by two or more physicians who are not involved in the transplantation procedure. Death shall be determined by the judgement of each physician.

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4. Resolution No. 4 carried (1989) 16:3 National 20.

5. "World Medical Association Adopts Declarations and Statements on Bioethical and Other Matters" (1988) 39:1 Int'l Dig. Health. Leg. 267.

In making this determination, each physician will use currently accepted scientific tests, and criteria that are consistent with the ethical requirements and professional standards established by the National Medical Association and other appropriate medical organizations in the community.

4. Whenever an experimental procedure such as the transplantation of animal organs or artificial organs is being considered, the physician should comply with the recommendations contained in the World Medical Association's Declaration of Helsinki, providing guidance for physicians in biomedical research involving human subjects.

(5) World Health Organization (WHO)

(a) WHO Guiding Principles on Human Organ Transplantation[6]

PREAMBLE

1. ... Over the past 30 years, organ transplantation has become a worldwide practice and has saved many thousands of lives. It has also improved the quality of life of countless other persons. Continuous improvements in medical technology, particularly in relation to tissue "rejection", have brought about expansion of the practice and an increase in the demand for organs. A feature of organ transplantation since its commencement has been the shortage of available organs. Supply has never satisfied demand, and this has led to the continuous development in many countries of procedures and systems to increase supply. Rational argument can be made to the effect that shortage has led to the rise of commercial traffic in human organs, particularly from living donors who are unrelated to recipients. There is clear evidence of such traffic in recent years, and fears have arisen of the possibility of related traffic in human beings. Health Assembly resolutions WHA40.13 and WHA42.5 are an expression of international concern over these developments.

2. These Guiding Principles are intended to provide an orderly, ethical, and acceptable framework for regulating the acquisition and transplantation of human organs for therapeutic purposes. The term "human organ" is understood to include organs and tissues but does not relate to human reproduction, and accordingly does not extend to reproductive tissues, namely ova, sperm, ovaries, testicles or embryos, nor is it intended to deal with blood or blood constituents for transfusion purposes. The Guiding Principles prohibit giving and receiving money, as well as any other commercial dealing in this field, but do not affect payment of expenditures incurred in organ recovery, preservation and supply. Of particular concern to WHO is the protection of minors and other vulnerable persons from coercion and improper inducement to donate organs.

Organs and tissues (referred to in this text as "organs") may be removed from the bodies of deceased and living persons for the purpose of transplantation only in accordance with the following Guiding Principles.

GUIDING PRINCIPLE 1

Organs may be removed from the bodies of deceased persons for the purpose of transplantation if:

(a) any consents required by law are obtained; and

(b) there is no reason to believe that the deceased person objected to such removal, in the absence of any formal consent given during the person's lifetime.

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6. Adopted by Resolution WHA44.25 of the 44th World Health Assembly, 13 May 1991; reprinted (1991) 42:3 Int'l Dig. Health Leg. 390. Since these principles were formalized after the Commission had adopted its recommendations, the Commission has not formally considered them.

GUIDING PRINCIPLE 2

Physicians determining that the death of a potential donor has occurred should not be directly involved in organ removal from the donor and subsequent transplantation procedures, or be responsible for the care of potential recipients of such organs.

GUIDING PRINCIPLE 3

Organs for transplantation should be removed preferably from the bodies of deceased persons. However, adult living persons may donate organs, but in general such donors should be genetically related to the recipients. Exceptions may be made in the case of transplantation of bone barrow and other acceptable regenerative tissues.

An organ may be removed from the body of an adult living donor for the purpose of transplantation if the donor gives free consent. The donor should be free of any undue influence and pressure and sufficiently informed to be able to understand and weigh the risks, benefits and consequences of consent.

GUIDING PRINCIPLE 4

No organ should be removed from the body of a living minor for the purpose of transplantation. Exceptions may be made under national law in the case of regenerative tissues.

GUIDING PRINCIPLE 5

The human body and its parts cannot be the subject of commercial transactions. Accordingly, giving or receiving payment (including any other compensation or reward) for organs should be prohibited.

GUIDING PRINCIPLE 6

Advertising the need for or availability of organs, with a view to offering or seeking payment, should be prohibited.

GUIDING PRINCIPLE 7

It should be prohibited for physicians and other health professionals to engage in organ transplantation procedures if they have reason to believe that the organs concerned have been the subject of commercial transactions.

GUIDING PRINCIPLE 8

It should be prohibited for any person or facility involved in organ transplantation procedures to receive any payment that exceeds a justifiable fee for the services rendered.

GUIDING PRINCIPLE 9

In the light of the principles of distributive justice and equity, donated organs should be made available to patients on the basis of medical need and not on the basis of financial or other considerations.

COMMENTARY ...

(b) WHO Resolution Preventing the Purchase and Sale of Human Organs[7]

The Forty-second World Health Assembly,

Concerned by the commercial trafficking in the organs of healthy donors, which exploits human distress and puts at increased risk the health of the donors;

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7. "World Health Assembly adopts Resolution on 'Preventing the Purchase and Sale of Human Organs'" (1989) 40:3 Int'l Dig. Health Leg. 724.

Aware that commercial arrangements for organ transplants are nevertheless being undertaken and that to date there has been little success in preventing trafficking in human organs;

Anxious to prevent the exploitation of human distress, particularly in children and other vulnerable groups, and to further the recognition of the ethical principles which condemn the buying and selling of organs for purposes of transplantation;

1. CALLS UPON Member States to take appropriate measures to prevent the purchase and sale of human organs for transplantation;

2. RECOMMENDS that Member States introduce legislation to prohibit trafficking in organs where this cannot effectively be prevented by other measures;

3. URGES Member States, in close cooperation with professional health organizations and supervising health authorities, to discourage all practices which facilitate commercial trafficking in organs;

4. REQUESTS Member States to report as soon as possible to WHO on action taken with respect to this resolution;

5. REQUESTS the Director-General to report to the Forty-fourth World Health Assembly the measures taken by the governments of Member States in furtherance of this resolution.

APPENDIX B

Selected Statutes — Excerpts

(1) Routine Inquiry/Required Request

(a) Manitoba (*The Human Tissue Act*, S.M. 1987-88, c. 39)

Consideration by physician.

4(1) Upon the death of a person in respect of whom no direction has been given under section 2 or 3 . . . the last physician to attend the deceased person before death shall . . . consider whether

(a) the condition of the body of the deceased person and of the tissue thereof;

(b) the need for the use of the body of the deceased person or any tissue from the body for therapeutic purposes; and

(c) the emotional and physical condition of the survivors of the deceased person;

are such that it is appropriate to request permission, in accordance with subsection (2), to use the body of the deceased person for therapeutic purposes or to remove tissue from the body to be used for therapeutic purposes.

Request after consideration.

4(2) A physician who upon consideration in accordance with subsection (1) in respect of a deceased person determines that it is appropriate to do so shall . . . request permission or cause permission to be requested from the deceased person's nearest relative . . . .

Exception.

4(3) This section does not apply where the last physician to attend a person before death has reason to believe

(a) that the use of the body of the deceased person or the removal and use of tissue from the body after death would be contrary to the person's religious beliefs or that the person, if living, would have objected thereto; or

(b) that an inquiry or investigation under *The Fatality Inquiries Act* may be required to be held . . .

(b) Oregon (Chapter 379, Laws 1985, House Bill No. 2909, approved July 3, 1985)

SECTION 1. (1) When death occurs in a hospital to a person who has not made an anatomical gift, the hospital administrator or designated representative shall request the person described in ORS 97.265(2), in order of priority stated when persons in prior classes are not available at the time of death, and in the absence of actual notice of contrary indication by the decedent or one in a prior class, to consent to the gift of all or any part of the decedent's body as an anatomical gift.

(2) Where such request is made, pursuant to this section, the request and its disposition shall be noted in the patient's medical record and on the death certificate and shall be documented as provided in ORS 97.275(5).

(3) Where, based on medical criteria, such request would not yield a donation which would be suitable for use, the Assistant Director for Health may, by rule, authorize an exception to the request required by this section.

(4) The Assistant Director for Health shall establish rules concerning the training of hospital employees who may be designated to perform the request, and the procedures to be employed in making it. In addition, the assistant director shall establish such rules as are necessary to implement appropriate procedures to facilitate the delivery of donations from receiving hospitals to potential recipients.

(5) The Assistant Director for Health shall establish such additional rules as are necessary for the implementation of this section.

(c) United States (*National Organ Transplant Act* of 1984)

42 USC § 1320b-8. Hospital protocols for organ procurement and standards for organ procurement agencies

(a) Establishment of protocols; . . .

(1) The Secretary shall provide that a . . . hospital meeting the requirements of subchapter XVIII or XIX [42 USCS §§ 1395 et seq., 1396 et seq.] of this chapter may participate in the program established under such subchapter only if —

(A) the hospital . . . establishes written protocols for the identification of potential organ donors that —

(i) assure that families of potential organ donors are made aware of the option of organ or tissue donation and their option to decline,

(ii) encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of such families, and

(iii) require that an organ procurement agency designated by the Secretary pursuant to subsection (b)(1)(F) of this section be notified of potential organ donors; . . .

(2) For purposes of this subsection, the term "organ" means a human kidney, liver, heart, lung, pancreas, and any other human organ or tissue specified by the Secretary for purposes of this subsection.

(d) Australia (ALRC, *Human Tissue Transplants*, Report 7 (Brisbane: Watson Ferguson and Co., 1977) at 127-28)

25. (3) Where the designated officer, after making such inquiries as are reasonable in the circumstances, has no reason to believe that the deceased person during his lifetime —

(a) had expressed the wish for, or consented to, the removal after his death of tissue from his body for the purpose or a use referred to in sub-section (1); or

(b) had expressed an objection to the removal after his death of tissue from his body for such a purpose or use,

and after making those inquiries and such further inquiries as are reasonable in the circumstances, the designated officer —

(c) has no reason to believe that the senior available next of kin of the deceased person has an objection to the removal of tissue from the body of the deceased person; or

(d) is unable to ascertain the existence or the whereabouts of the next of kin of the deceased person or is unable to ascertain whether any of the next of kin of the deceased person has an objection to the removal of tissue from the body of the deceased person,

the designated officer may authorize under sub-section (1) the removal of tissue from the body of the deceased person for the purpose or a use referred to in that sub-section.

(2) Tissue Sales Prohibitions

(a) Canada

i. *Uniform Human Tissue Gift Act* (Sales Prohibition), Uniform Law Conference Canada 1971 Proceedings (in effect in most provinces)

Sale, etc., of tissue prohibited

10. No person shall buy, sell or otherwise deal in, directly or indirectly, for a valuable consideration, any tissue for a transplant, or any body or part or parts thereof other than blood or a blood constituent, for therapeutic purposes, medical education or scientific research, and any such dealing is invalid as being contrary to public policy.

1. In this Act, ...

(c) "tissue" includes an organ, but does not include any skin, bone, blood, blood constituent or other tissue that is replaceable by natural processes of repair; ...

ii. *Uniform Human Tissue Donation Act* (1989), Uniform Law Conference of Canada

Commerce prohibited

15. (1)No person shall buy, sell or otherwise Prohibiteddeal in, directly or indirectly, any tissue, body or body part for the purpose of a transplant or for a therapeutic purpose, medical education or scientific research.

(2) Any dealing in any tissue, body or body part that was lawful before this Act came into force shall continue to be lawful, provided this Act is complied with.

(3) A person who contravenes this section is guilty of an offence and liable on summary conviction to a fine of not more than $100,000 or to imprisonment for not more than 1 year, or to both.

1. In this Act,

...

"tissue" means a part of a living or dead human body, but does not include

(a) spermatozoa or ova,

(b) an embryo or fetus, or

(c) blood or blood constituents; ("tissu")

iii. Manitoba (*The Human Tissue Act*, S.M. 1987-88, c. 39)

Sale, purchase, trafficking prohibited.

15(2) No person shall, for any purpose,

(a) sell or buy any dead human body, or any tissue from a human body whether living or dead; or

(b) traffic in dead human bodies or tissue from human bodies whether living or dead; ...

Exception as to remuneration.

15(3) Nothing in this section prohibits the payment of reasonable remuneration to a physician or other health professional for services rendered for the purpose of carrying out a direction or complying with a consent under this Act.

Exception as to expenses.

15(4) Nothing in this section prohibits reimbursement, to the donor or recipient of a body or tissue from a body, or to the family or survivors of such a donor or recipient, or to any government or private medical or hospital plan, as the case may require, of reasonable expenses incurred in . . .

Offence and penalty.

15(5) Any person who contravenes or fails to observe a provision of this section is guilty of an offence and liable on summary conviction to a fine of not more than $5,000, or to imprisonment for a term of not more than six months or to both.

(b) Great Britain (*Human Organ Transplants Act 1989*, 1989, c. 31)

Offers, acceptance, brokers

1. — (1) A person is guilty of an offence if in Great Britain he —

(a) makes or receives any payment for the supply of, or for an offer to supply, an organ which has been or is to be removed from a dead or living person and is intended to be transplanted into another person in Great Britain or elsewhere;

(b) seeks to find a person willing to supply for payment such an organ as is mentioned in paragraph (a) above or offers to supply such an organ for payment;

(c) initiates or negotiates any arrangement involving the making of any payment for the supply of, or for an offer to supply, such an organ; or

(d) takes part in the management or control of a body of persons corporate or unincorporate whose activities consist of or include the initiation or negotiation of such arrangements.

(2) . . . if he causes to be published or distributed, or knowingly publishes or distributes, in Great Britain an advertisement —

(a) inviting persons to supply for payment any such organs as are mentioned [above] or offering to supply any such organs for payment; or

(b) indicating that the advertiser is willing to initiate or negotiate any such arrangement as is mentioned [above].

(3) [payment does not include]

(a) the cost of removing, transporting or preserving the organ to be supplied; or

(b) any expenses or loss of earnings incurred by a person so far as reasonably and directly attributable to his supplying an organ from his body.

(c) United States (*National Organ Transplant Act* of 1984)

42 USC § 274e. Prohibition of organ purchases (emphasis added)

(a) Prohibition

It shall be unlawful for any person to *knowingly* acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce.

(b) Penalties

Any person who violates subsection (a) . . . shall be fined not more than $50,000 or imprisoned not more than five years, or both.

(c) Definitions

For purposes of subsection (a) . . . :

(1) The term "human organ" means the human (including fetal) kidney, liver, heart, lung, pancreas, bone marrow, cornea, eye, bone, and skin or any subpart thereof and any other human (or any subpart thereof, including that derived from a fetus) specified by the Secretary of Health and Human Services by regulation.

(2) The term "valuable consideration" does not include the reasonable payments associated with the removal, transportation, implantation, processing, preservation, quality control, and storage of a human organ or the expenses of travel, housing, and lost wages incurred by the donor of a human organ in connection with the donation of the organ.

(d) Council of Europe (Final Text on Organ Transplantation, (1988) 39:1 Int'l Dig. Health Leg. 274 at 277)

The Non-Commercialisation of Human Organs

16. A human organ must not be offered for profit by any organ exchange organisation, organ banking centre or by any other organisation or individual whatsoever. However, this does not prevent the compensation of living donors for loss of earnings and any expenses caused by the removal or preceding examination.

17. Neither organisations nor individuals should advertise outside their national territory either for donation or transplantation.

(3) *Uniform Human Tissue Donation Act* (1989)[1]

Definitions

1. In this Act,

"common law spouse"
"common law spouse" means [insert provincial definition]; ("conjoint de fait")

"death"
"death" includes brain death as determined by generally accepted medical criteria; ("mort")

"non-regenerative tissue"
"non-regenerative tissue" means tissue other than regenerative tissue; ("tissu non susceptible de régénération")

"regenerative tissue"
"regenerative tissue", in a living human body, means tissue that, on injury or removal, replaces itself; ("tissu[e] susceptible de régénération")

"spouse"
"spouse" includes a common law spouse; ("époux; épouse")

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1. Uniform Law Conference of Canada, *Consolidation of Uniform Acts* (1990 Supp.) 22-1. Available for adoption by the Provinces 1 January 1990.

"tissue"

"tissue" means a part of a living or dead human body, but does not include

(a) spermatozoa or ova,

(b) an embryo or fetus, or

(c) blood or blood constituents; ("tissu")

"transplant"

"transplant" means the removal of tissue from a human body and the implantation of the tissue in the living human body of another. ("transplantation")

Compliance with Act

2. A consent to the removal of tissue may be given in accordance with this Act, but not otherwise.

Consent to transplant after death

3. (1) A person who is [16] years of age or over and understands the nature and consequences of transplanting tissue from his or her body after death may consent to the removal of the tissue specified in the consent from his or her body after death for the purpose of implanting the tissue in a living human body.

(2) Not withstanding subsection (1), a consent given by a person who did not understand the nature and consequences of transplanting tissue from his or her body after death is valid for the purposes of this section if the person who acts on it has no reason to believe that the person who gave it did not understand the nature and consequences of transplanting tissue from his or her body after death.

Substituted consent

4. (1) After the death of a person who has not given a consent under section 3, who is under [16] years of age or who did not understand the nature and consequences of transplanting tissue from his or her body after death, a person referred to in subsection (2) may consent to the removal of the tissue specified in the consent from the body of the deceased

(a) for the purpose of implanting the tissue in a living human body, or

(b) for the purposes referred to in section 12(1).

(2) A consent referred to in subsection (1) may be given by any one of the following:

(a) a guardian of the person of the deceased before death;

(b) the spouse of the deceased;

(c) a child of the deceased;

(d) a parent of the deceased;

(e) a brother or sister of the deceased;

(f) any other relative of the deceased;

(g) a person, other than a spouse, who shared a residence with the deceased immediately before the deceased died and has knowledge of the wishes of the deceased.

(3) In the event of a dispute between persons in 2 or more of the classes of persons referred to in subsection (2), the dispute shall be decided in accordance with the order in which those classes are listed in subsection (2).

(4) If no consent is provided under subsection (1) and the [Coroner], after making reasonable efforts, is unable to locate any of the persons listed in subsection (2), the [Coroner] may be given a consent referred to in subsection (1).

(5) No consent may be given under this section by a person who

(a) is under [16] years of age,

(b) does not understand the nature and consequences of transplanting tissue from the body of the deceased after death, or

(c) has reason to believe that the deceased would have objected to the consent.

Consent to transplant during life

5. (1) A person who is [16] years of age or over and understands the nature and consequences of transplanting tissue from his or her body during his or her life may consent to the removal of the tissue specified in the consent from his or her body during his or her life for the purpose of implanting the tissue in another living human body.

(2) If there is reason to believe that a person who gives a consent under this section may not understand the nature and consequences of transplanting tissue from his or her body during his or her life, no transplant may be carried out pursuant to that consent unless the results of an independent assessment conducted in accordance with section 7 indicate that the transplant should be carried out.

(3) No transplant of non-regenerative tissue may be carried out pursuant to this section unless the results of an independent assessment conducted in accordance with section 7 indicate that the transplant should be carried out.

Transplant during life re person under 16

6. (1) A person who is under [16] years of age and understands the nature and consequences of transplanting tissue from his or her body during his or her life may consent to the removal of the regenerative tissue specified in the consent from his or her body during his or her life for the purpose of implanting the tissue in another living human body.

(2) Notwithstanding subsection (1), bone marrow may be removed from a person who is under [16] years of age and does not understand the nature and consequences of transplanting tissue from his or her body during his or her life for the purpose of implanting the bone marrow in a biological brother or biological sister of the donor.

(3) No transplant may be carried out

(a) pursuant to subsection (1), unless a parent or guardian of the donor also consents to the transplant, or

(b) pursuant to subsection (2), unless a parent or guardian of the donor consents to the transplant on behalf of the donor.

(4) No transplant may be carried out pursuant to subsection (1) or (2) unless the results of an independent assessment conducted in accordance with section 7 indicate that the transplant should be carried out.

Independent assessment

7. (1) If an independent assessment is required pursuant to this Act, it shall be conducted in accordance with this section and the regulations.

(2) An independent assessment shall be conducted by not fewer than 3 persons, of whom one shall be a physician.

(3) No person who has or has ever had an association with the donor of tissue in respect of whom an independent assessment is conducted or with the proposed recipient of the tissue shall conduct the independent assessment.

(4) The persons conducting an independent assessment shall provide notice of the date, time and place of the independent assessment to

(a) the donor of the tissue,

(b) if the donor is under [16] years of age, the parent or guardian of the donor and the [Official Guardian], and

(c) if the donor is [16] years of age or over and there is reason to believe that the donor may not understand the nature and consequences of transplanting tissue from his or her body during his or her life, the parent or guardian of the person of the donor and the [Official Guardian].

(5) On receiving a notice under subsection (4), the [Official Guardian] shall represent the donor at the independent assessment unless the [Official Guardian] is satisfied that another person in addition to the parent or guardian of the person of the donor will represent the donor.

(6) The persons conducting an independent assessment shall consider the following:

(a) whether the transplant is the medical treatment of choice;

(b) with respect to a transplant under section 6, whether all other members of the immediate family of the donor have been eliminated, for medical or other reasons, as potential donors;

(c) whether coercion has been exerted on the donor for the purpose of obtaining his or her consent to the transplant;

(d) whether the removal of the tissue from the body of the donor will create a substantial health or other risk to the donor;

(e) whether this Act and the regulations, as they relate to that transplant, have been complied with.

(7) The persons conducting an independent assessment shall, in the manner and within the time period prescribed in the regulations,

(a) make a decision as to whether a transplant that has been proposed pursuant to section 5 or 6 should be carried out,

(b) provide written reasons for the decision, and

(c) provide notice of that decision and the reasons for the decision to the persons who received notice of the independent assessment under subsection (4).

Appeal

8. (1) A person may, within [3 days] after a decision has been made under section 7(7), appeal to the [Supreme Court] the decision of the persons who conducted an independent assessment.

(2) On hearing an appeal, the Court may

(a) quash, vary or confirm the decision of the persons who conducted the independent assessment, or

(b) refer the matter back to the persons who conducted the independent assessment for further action in accordance with the directions of the Court.

(3) On hearing an appeal to which section 6(2) applies, the Court may make an order authorizing a parent or guardian of the donor to consent to the transplant on behalf of the donor.

(4) No transplant in respect of which an appeal has been commenced under subsection (1) shall be carried out until the appeal has been concluded.

Effect of consent

9. (1) A consent that complies with this Act is binding and is authority for a physician

(a) to make an examination necessary to assure medical acceptability of the tissue specified in the consent, and

(b) to remove the tissue specified in the consent in accordance with the consent.

(2) Notwithstanding subsection (1), no person shall act on a consent if the person has reason to believe that

(a) in the case of a consent under section 3, 5, 6 or 12, the person who gave the consent subsequently withdrew or would have objected to the consent, or

(b) in the case of a consent under section 4, the person on whose behalf the consent was given would have objected to the consent.

Coroner's direction

10. If, in the opinion of a physician, the death of a person is imminent by reason of injury or disease and the physician has reason to believe that section ... of the [Coroners Act] may apply when death does occur and a consent under section 3 has been obtained for a transplant of tissue from the body after death, a [Coroner] having jurisdiction, notwithstanding that death has not yet occurred, may give directions he or she thinks proper respecting the removal of the tissue after the death of the person, and that direction has the same force and effect as if it had been made after death under section ... of the [Coroners Act].

Determination of death

11. (1) The fact of death of a donor of tissue shall be determined by at least 2 physicians in accordance with accepted medical practice.

(2) No physician who has had an association with the proposed recipient of tissue shall take any part in the determination of the fact of death of the donor of that tissue.

(3) No physician who took any part in the determination of the fact of death of the donor of tissue shall participate in any way in the transplant of that tissue.

(4) Subsections (2) and (3) do not apply to a physician in the removal of eyes for cornea transplants.

Consent for other purposes

12. (1) Notwithstanding anything in this Act, a person who is [16] years of age or over may consent to the use after death of his or her body or the parts of his or her body specified in the consent for therapeutic purposes, medical education or scientific research.

(2) If tissue that has been removed pursuant to a consent given under section 3, 4, 5 or 6 cannot for any reason be implanted in a living human body, the tissue shall be disposed of as if no consent relating to the tissue had been given, unless the donor has consented to the use of the tissue for therapeutic purposes, medical education or scientific research.

Disclosure of information

13. (1) Except where required by law, no person shall disclose or give to another person any information or document whereby the public may learn the identity of a person

(a) who has given or refused to give a consent to the removal of tissue,

(b) with respect to whom a consent to the removal of tissue has been given or refused, or

(c) into whose body tissue has been, is being or may be implanted.

(2) Notwithstanding subsection (1),

(a) a donor of tissue may disclose or authorize another person to disclose information relating only to the donor that the donor has authorized for disclosure,

(b) a recipient of tissue may disclose or authorize another person to disclose information relating only to the recipient that the recipient has authorized for disclosure, and

(c) a person who gave a consent under section 4 on behalf of a deceased may disclose or authorize another person to disclose information relating only to the deceased that the person who gave the consent has authorized for disclosure.

Protection from liability

14. No person is liable for anything done or omitted to be done in good faith and without negligence in the exercise or intended exercise of an authority under this Act.

Commerce prohibited

15. (1) No person shall buy, sell or otherwise deal in, directly or indirectly, any tissue, body or body part for the purpose of a transplant of for a therapeutic purpose, medical education or scientific research.

(2) Any dealing in any tissue, body or body part that was lawful before this Act came into force shall continue to be lawful, provided this Act is complied with.

(3) A person who contravenes this section is guilty of an offence and liable on summary conviction to a fine of not more than $100,000 or to imprisonment for not more than 1 year, or to both.

General offence

[16. A person who contravenes this Act, except section 15, is guilty of an offence and liable on summary conviction to a fine of not more that $10,000 or to imprisonment for not more than 6 months, or to both.]

Regulations

17. The Lieutenant Governor in Council may make regulations

(a) respecting the establishment and operation of independent assessments;

(b) prescribing the manner and time period in which a decision under section 7(7), reasons for the decision and notice of the decision shall be given.

Repeal

18. The Uniform Human Tissue Gift Act is repealed.

APPENDIX C

Table of Cases

Canada

Andrews v. *Law Society of British Columbia*, [1989] 1 S.C.R. 143.
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APPENDIX D

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List of Our Reports and Working Papers

Reports to Parliament

1. *Evidence** (December 19, 1975)
2. *Guidelines — Dispositions and Sentences in the Criminal Process** (February 6, 1976)
3. *Our Criminal Law* (March 25, 1976)
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Commission de réforme
du droit du Canada

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Note de la rédaction

Le lecteur est prié de noter que la base documentaire du présent document était à jour en juillet 1990, date à laquelle la Commission a approuvé les recommandations énoncées au chapitre cinq. Toutefois, certains renseignements ont été mis à jour en 1991.

Conformément à la recommandation formulée dans le document intitulé *Égalité pour tous — Rapport du Comité parlementaire sur les droits à l'égalité*, nous nous sommes fait un devoir de rédiger le présent document de travail dans une langue non sexiste. Dans cette optique, et puisque le mandat de la Commission consiste à formuler des propositions en vue de moderniser les lois fédérales canadiennes, nous nous sommes conformés aux principes énoncés dans l'ouvrage publié sous le titre *Cap sur l'égalité — Réponse au Rapport du Comité parlementaire sur les droits à l'égalité*, relativement à la rédaction des textes législatifs. Le genre grammatical des noms et pronoms utilisés pour désigner des personnes (« médecin », « patient », etc) ne doit donc en aucun cas être interprété comme une indication du sexe de ces personnes.

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La nature même des questions suscitées par les révolutions dont le dernier quart de siècle a été témoin dans les domaines de la médecine et de la technologie biomédicale obligent la Commission à demander à divers secteurs de la société d'éclairer ses discussions et ses analyses. Dans cette perspective, elle a élargi et officialisé en 1989 son processus de consultation sur les problèmes d'ordre médical et juridique. La Commission a en effet mis sur pied un comité consultatif multidisciplinaire, le Groupe consultatif d'experts en droit de la santé. Le comité a généreusement accepté de prêter son concours à la préparation de ce document.

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Il va sans dire que les opinions formulées dans ce document ne reflètent pas nécessairement la position du Parlement ou du ministère de la Justice, ni l'opinion individuelle des personnes consultées.

Introduction

Encore une fois, la médecine moderne force le droit à s'interroger sur les règles applicables à l'égard du corps humain se trouvant aux frontières de la vie et de la mort. Il y a dix ans, la Commission de réforme du droit du Canada, de concert avec plusieurs analystes, recommandait l'adoption de nouveaux critères de détermination de la mort[1]. Les nouveaux outils à la disposition de la médecine — respirateurs mécaniques, appareils assurant la circulation sanguine, etc. — en étaient venus à obscurcir la signification et l'utilité du critère traditionnel, à savoir l'arrêt des fonctions cardiaques et pulmonaires.

Le patient hospitalisé chez qui il n'y aurait plus aucune réaction ni fonction cérébrale, mais dont le corps serait pendant une période indéfinie maintenu en vie par des moyens mécaniques, devrait-il être considéré comme mort ou comme vivant, sur le plan juridique ? La réponse à cette question est devenue plus claire, le critère de la mort cérébrale constituant maintenant la norme courante tant pour la médecine que pour le droit. Une telle réforme juridique diminue l'incertitude et la confusion, et cette nouvelle certitude fournit aux familles et aux professionnels de la santé une norme contemporaine face à certaines situations où des patients sont à la limite de la vie et de la mort. Par ailleurs, la transplantation des organes d'une personne qui vient de mourir nécessite le branchement du cadavre à des appareils, de façon que les organes du donneur puissent être conservés jusqu'au moment de l'intervention. La clarté permise par le nouveau critère de détermination de la mort a ainsi facilité les prélèvements et les transplantations d'organes.

Au cours des dix années écoulées depuis la proposition de la Commission de réforme du droit, la technologie des transplantations et du remplacement de tissus humains a atteint le stade de la maturité. Les progrès de la médecine ont révolutionné les possibilités thérapeutiques de la transplantation d'organes, de tissus et d'ensembles cellulaires ou génétiques humains. La mise au point de nouveaux médicaments, l'amélioration des procédures ont augmenté le taux de survie des receveurs ; elles ont en outre contribué à faire des greffes du foie et du cœur un traitement médical normal, au même titre que les greffes du rein, devenues courantes il y a déjà un certain temps dans la société canadienne.

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1. Commission de réforme du droit du Canada [ci-après CRD], *Les critères de détermination de la mort*, Rapport n° 15, Ottawa, Approvisionnements et Services Canada, 1981.

Cependant, les progrès de la haute technologie médicale dans la lutte contre la maladie et la mort n'ont pas été sans amener certaines difficultés. Les chirurgiens affirment que la pénurie d'organes est critique. Dans tous les centres de transplantation du pays, les listes d'attente pour les greffes d'yeux, de reins et de foie sont la règle. L'existence de ces listes d'attente, le sentiment de frustration des médecins et la perte de vies que l'on aurait pu sauver, amènent à conclure que la situation est à l'origine de drames individuels et collectifs. Les résultats de cette apparente rareté d'organes et de tissus pèsent sur le régime actuel, fondé sur les principes de l'autonomie, du respect de la volonté, de la protection de l'intégrité corporelle et du respect à l'égard des morts et de leurs proches parents. Ils conduisent certains à réclamer des réformes — des réformes susceptibles par certains aspects de heurter les valeurs et les postulats du système en vigueur.

Ainsi, de nouvelles questions se font jour. L'apparente rareté de tissus et d'organes justifie-t-elle des réformes juridiques ? Dans l'affirmative, en quoi devraient-elles consister ? Y a-t-il lieu de modifier le critère de la mort cérébrale, dans le cas des bébés qui naissent dépourvus de la partie supérieure de l'encéphale et meurent généralement dans les soixante-douze heures suivant la naissance, afin de faciliter le prélèvement d'organes sur eux ? La commercialisation de parties ou de substances du corps est-elle une façon acceptable d'augmenter les quantités de sang, de tissus humains et d'organes pouvant être utilisés à des fins thérapeutiques ? Ou, au contraire, devrait-on qualifier crime la vente de certaines de ces parties ou substances, afin de décourager les actes suscités par le désespoir médical et économique, et de préserver des valeurs fondamentales ? Devant l'inquiétude grandissante suscitée par le trafic international d'organes, l'Organisation mondiale de la santé a exhorté la communauté internationale à prendre des mesures en vue de prévenir et de décourager ces transactions[2]. L'OMS a déclaré que la transplantation d'organes est un phénomène biomédical qui menace l'intégrité morale et juridique de l'individu[3].

Si les réponses ne sont pas aussi claires que la société canadienne le souhaiterait, ces questions seront vraisemblablement étudiées et débattues de plus en plus souvent, la médecine découvrant sans cesse de nouvelles façons d'utiliser le corps humain à des fins thérapeutiques. Il existe toutefois des précédents historiques. Deux controverses, l'une assez ancienne et l'autre récente, donnent à penser que les questions d'ordre médical et juridique soulevées par le déséquilibre apparent entre la demande médicale et l'offre de tissus et de substances du corps humain ne se posent pas uniquement dans le cas des transplantations.

La première date d'environ un siècle et demi. A l'automne 1843, soit près de vingt ans après l'établissement de la première faculté de médecine au Canada par l'Université McGill, le conseil médical de Montréal a, par requête, demandé à l'Assemblée législative de la Province du Canada d'adopter une loi sur l'anatomie. Cette requête faisait suite à des incidents nocturnes au cours desquels des étudiants de la faculté de médecine s'étaient

2. Voir la Résolution de 1989 de l'OMS, *infra*, note 1047 et reproduite à l'annexe A, *infra*, p. 231.

3. ORGANISATION MONDIALE DE LA SANTÉ, *L'élément santé dans la protection des droits de l'homme face aux progrès de la biologie et de la médecine*, Genève, l'Organisation, 1976.

procurés des cadavres dans des cimetières de Montréal, provoquant l'indignation publique et poussant la population à réclamer des mesures pour mettre un terme à ces actes de "grossière indécence"[4]. Ailleurs au Canada, le manque de spécimens humains poussait depuis des années les étudiants en médecine, voire les professeurs d'anatomie, à recourir à de tels procédés[5].

Les requérants réclamaient donc l'adoption d'une loi sur l'anatomie qui réglementerait l'obtention, par les facultés de médecine, des cadavres dont elles avaient besoin pour la dissection et l'anatomie. La situation nuisait selon eux à l'enseignement et à la pratique de la médecine, au détriment du public[6]. La réforme demandée, disaient-ils, allait permettre de faire cesser la violation des sépultures, le trafic de cadavres et d'autres abus semblables liés à l'existence d'un marché noir. À ces arguments, le camp adverse répliquait qu'il serait préférable de mettre à la disposition des facultés les cadavres de criminels, que la loi proposée légaliserait le « trafic des dépouilles » et que les cadavres deviendraient ainsi des biens publics[7]. Le débat se terminera par l'adoption, en décembre 1843, de l'*Acte pour régler et faciliter l'étude de l'Anatomie*[8]. Le législateur y établissait le principe suivant lequel les cadavres non réclamés, exposés publiquement ou dans des institutions publiques tels les hôpitaux, devaient être mis à la disposition des facultés de médecine et servir de sujets d'anatomie.

Les notions de « vente » et de « bien » utilisés à propos du corps humain dans ce débat du siècle dernier ont refait surface dans le cadre d'une controverse plus récente, axée sur la protection juridique des patients et le sens de l'intégrité corporelle en cette ère de la biotechnologie. Dans une affaire soumise récemment aux tribunaux américains, un patient atteint de leucémie a intenté des poursuites contre son médecin et un hôpital universitaire, à qui il reprochait d'avoir, à son insu ou sans son consentement, utilisé ses cellules pancréatiques pour mettre au point une « lignée cellulaire » présentant un grand intérêt thérapeutique[9]. Cette lignée cellulaire a servi à la fabrication de nouveaux médicaments contre le cancer ; sa valeur commerciale est telle qu'un brevet a été délivré. Le patient, faisant valoir qu'on avait prélevé sans son consentement des substances corporelles lui appartenant, revendiquait sa juste part des revenus d'exploitation du brevet.

Aucune affaire de ce genre n'a été signalée au Canada. Néanmoins, la cause montre quels litiges peuvent surgir entre, d'une part, les personnes sur qui on prélève des cellules et des tissus, et, d'autre part, celles qui se procurent et utilisent les cellules et les tissus en cause. L'affaire *Moore* laisse entrevoir la valeur économique et commerciale sans précédent que des substances et des produits du corps humain peuvent atteindre, grâce aux percées de la biotechnologie médicale et à la protection juridique accordée relativement aux fruits commerciaux qu'on en tire. Elle semble par ailleurs marquer de façon

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4. Voir D.G. LAWRENCE, « "Resurrection" and Legislation or Body-Snatching in Relation to the Anatomy Act in the Province of Quebec » (1958), 32:5 *Bull. Hist. Med.* 408, 411.

5. Voir E.D. WORTHINGTON, *loc. cit.*, note 809.

6. Voir Débats, *op. cit.*, note 803, pp. 464-467.

7. *Ibid.*

8. S. Prov. C. 1843, ch. 5 [ci-après la *Loi sur l'anatomie*]. Voir *infra*, ch. III, section III.B(1).

9. Voir *Moore* c. *Regents of the University of California*, *infra*, note 426.

symbolique une importante étape de transition dans laquelle sont engagées le droit et la société. Cette étape se caractérise par les efforts déployés pour définir la teneur des régimes juridiques qui vraisemblablement s'appliqueront, au XXI[e] siècle, aux prélèvements, aux greffes et aux transplantations ainsi, qu'aux autres techniques de remplacement des tissus humains.

C'est le contexte dans lequel s'inscrivent ces méthodes thérapeutiques qui suscite une question plus large : le droit permet-il de répondre à la demande médicale moderne, en ce qui a trait à l'utilisation d'organes et de produits prélevés sur des corps humains ? Les débats de 1843 concernant la loi sur l'anatomie se rapprochent des préoccupations qui s'expriment aujourd'hui dans le cadre des discussions sur les moyens à envisager pour favoriser l'offre d'organes prélevés sur des cadavres. Une fois encore, les analystes se demandent si le droit entrave l'offre de tissus humains et de substances corporelles, ou si au contraire il la réglemente adéquatement. Et du fait que les tissus recherchés de nos jours sont destinés à être greffés ou transplantés sur le corps d'un patient, ou bien à lui être transfusés, la protection du receveur est devenue une préoccupation. Si des réformes sont de mise sur le plan juridique, en quoi devraient-elles consister, s'agissant des droits, des devoirs et de la recherche d'un juste équilibre entre les intérêts en jeu ?

En cherchant des réponses à ces questions, nous avons étudié les aspects médicaux et juridiques du prélèvement et de l'utilisation médicale des tissus humains et des substances corporelles, par rapport aux techniques de remplacement de tissus qui font leur apparition. Nous nous sommes vite rendu compte que les réponses à certaines des questions épineuses soulevées par les progrès de la technique sont vraisemblablement liées aux conséquences éthiques du réductionnisme croissant dont la médecine fait preuve à l'égard du corps humain. Si l'on reste déconcerté devant la facilité avec laquelle la médecine réduit le corps humain à ses éléments biologiques pour des motifs thérapeutiques, c'est notamment parce que cette attitude touche également des valeurs et des conceptions sociales fondamentales reliées à l'utilisation du corps humain, mort ou vivant. La science médicale continuera de mettre au point des techniques de plus en plus perfectionnées permettant de produire des agents thérapeutiques modernes à partir d'éléments et de substances du corps humain naguère inutiles. Cette tendance, et toutes ses répercussions sociales, nous ont convaincus que, pour comprendre la façon dont le droit et la médecine conçoivent le corps humain, il est impératif de saisir l'évolution de notre conception éthique. D'un point de vue historique, l'étude de ces questions nous amène donc à suivre l'évolution des règles de droit concernant le corps humain, et leurs fondements éthiques, depuis l'ère de l'anatomie, au XIX[e] siècle, jusqu'à l'ère des transplantations et de la biotechnologie.

Tel est le cadre élargi dans lequel la Commission a entrepris l'élaboration du présent document de travail. Elle a tenu compte des importants travaux réalisés dans ce domaine au milieu des années quatre-vingt par différents groupes de travail fédéraux, territoriaux[10] et provinciaux[11], des initiatives de réforme législative plus récentes émanant des provinces

10. Voir *infra*, note 29.

11. Voir *infra*, notes 29 et 143.

et de la Conférence sur l'uniformisation des lois au Canada[12], ainsi que des déclarations d'organismes internationaux et de certains États étrangers[13]. Son travail s'inspire de ces contributions et vise à les compléter.

Il faut donc voir dans le présent document l'analyse et les réflexions initiales de la Commission sur les grandes questions d'ordre juridique que suscite le régime actuellement en vigueur dans la société canadienne, dans le domaine du prélèvement et de l'utilisation médicale de tissus humains. Le chapitre premier est consacré à la demande médicale de tissus humains et de substances corporelles, ainsi qu'à l'offre ; on y étudie également les dilemmes d'ordre juridique et éthique provoqués par le déséquilibre entre cette demande et cette offre. Le chapitre II consiste dans une analyse des considérations éthiques sous-jacentes. Au chapitre III, on examine le droit actuel touchant le corps humain, du point de vue de la common law, du droit civil et du droit pénal, les textes législatifs anciens et actuels sur le prélèvement de tissus humains ainsi que les répercussions sur les droits de la personne. Au chapitre IV, on expose les principales solutions législatives adoptées à l'étranger, et l'on étudie les problèmes juridiques que suscitent les échanges internationaux de tissus humains thérapeutiques et de techniques de remplacement des tissus. Le chapitre V consiste dans une brève description des arguments qui militent pour et contre les principales solutions envisageables dans le cadre d'une réforme législative, un énoncé de principes généraux et un résumé des recommandations de la Commission.

Les tissus fœtaux ainsi que les gamètes et les embryons humains, parce qu'ils soulèvent des préoccupations particulières, ont été exclus de notre analyse. Ne font pas non plus directement l'objet de celle-ci les problèmes cruciaux liés à l'attribution des ressources médicales insuffisantes. Le présent document est axé sur le prélèvement et l'utilisation médicale de tissus humains.

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12. Voir *infra*, pp. 151-158.

13. Voir *infra*, ch. IV.

CHAPITRE PREMIER

Les besoins de la médecine moderne : la « demande » et l'« offre »

Ce que l'on pourrait appeler « l'offre et la demande », dans le contexte de l'utilisation des substances corporelles et des tissus humains, est lié à plusieurs éléments, dont l'évolution des besoins médicaux et de l'exercice de la médecine. Nous examinerons dans ce chapitre la « demande » (anatomie, transplantations et greffes, biotechnologie) en regard de l'« offre » (prélèvement de tissus et d'organes sur des donneurs vivants et morts, sources synthétiques et artificielles, banques de tissus humains). Nous découvrirons ainsi l'existence de vives tensions entre les besoins en pleine évolution de la thérapeutique, et l'ingéniosité croissante dont la science médicale fait preuve dans le remplacement des tissus, qui lui permet en quelque sorte de « reconstituer » le corps humain. Nous verrons aussi quels sont les principaux éléments d'ordre non médical influant sur l'offre et la demande, et nous évoquerons les problèmes d'ordre éthico-juridique qu'il faudra étudier de plus près dans les chapitres subséquents. Le chapitre se termine par un résumé des principaux éléments qui régissent l'évolution de l'offre et de la demande.

I. La demande

La demande provenant de la thérapeutique moderne est fondée sur l'utilisation de tissus humains, de parties du corps humain et de substances corporelles dans trois domaines : l'enseignement de la médecine, la recherche médicale et le traitement. Elle témoigne de la convergence de trois phases — anatomie, transplantations et greffes, biotechnologie — dans l'exercice actuel de la médecine.

A. La demande relative à l'anatomie

Une grande partie de nos connaissances sur les maladies et leur traitement ont été acquises grâce à l'anatomie humaine. Étymologiquement, le mot « anatomie », d'origine grecque, signifie « couper, découper » ; par conséquent, l'anatomie humaine désigne classiquement l'étude de la structure et du fonctionnement du corps humain par la dissection[14].

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14. Voir Doris Burda Wilson et Wilfred J. Wilson, *Human Anatomy*, 2e éd., New York, Oxford University Press, 1983, p. 3.

La dissection et l'anatomie existent depuis plus de 4 000 ans, mais la naissance de l'anatomie moderne est intimement liée à l'essor des facultés de médecine en Europe au cours du XIII^e siècle[15]. Les chartes de certaines universités[16] fondées durant la Renaissance comportaient même des dispositions autorisant l'utilisation de cadavres pour l'enseignement de la médecine, à une époque où les superstitions et certains sentiments religieux[17] s'opposaient aux contacts avec les dépouilles et même les condamnaient. La nécessité pratique a également contribué à modifier les attitudes ; on pourrait sans doute citer à titre d'exemple les dissections effectuées sur les cadavres des victimes de la peste noire qui a balayé l'Europe à la fin de la période médiévale[18]. La publication au XVI^e siècle du traité d'André Vésale intitulé *De Humani Corporis Fabrica Libri Septem*, sur lequel est fondée l'anatomie moderne[19], a contribué à uniformiser les méthodes de la dissection et à faire de celle-ci une matière de base dans les facultés de médecine. L'ouvrage incita Charles V, empereur du Saint Empire romain germanique à l'époque, à soumettre le problème de l'anatomie à un conseil théologique. Le conseil, par sa réponse favorable, allait définitivement assurer le recours à la dissection humaine comme moyen de faire progresser l'anatomie et la pathologie[20]. Ainsi, dès le XIX^e siècle, les étudiants en médecine devaient, avant d'obtenir leur diplôme, avoir disséqué un corps humain[21].

Aujourd'hui, l'anatomie humaine fait partie intégrante du programme d'études des vingt-deux facultés de médecine canadiennes. C'est un cours obligatoire pour les étudiants en médecine, en sciences infirmières, en physiothérapie, en dentisterie et en ergothérapie. Cette exigence des facultés de médecine repose sur une idée bien simple : si l'on n'apprend pas la structure et le fonctionnement du corps humain pendant ses études, dans les laboratoires d'anatomie et de dissection, on l'apprendra dans l'exercice de la médecine, en « mutilant les vivants »[22]. Autrement dit, la connaissance des tissus, des organes et des principaux systèmes du corps humain est réputée essentielle pour comprendre, prévenir et traiter la maladie.

Pour acquérir une telle connaissance, il a depuis longtemps fallu se procurer des cadavres humains comme spécimens d'anatomie, comme le démontrent les débats entourant

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15. Voir T.V.N. PERSAUD, *Early History of Human Anatomy*, Springfield, Ill., Charles Thomas, 1984, pp. 77-88. Voir en général Arthur M. LASSEK, *Human Dissection: Its Drama and Struggle*, Springfield, Ill., Charles Thomas, 1958.

16. Voir Sonoma COOPER, « The Medical School of Montpellier in the Fourteenth Century » (1930), 2 (N.S.) *Ann. Med. Hist.* 164, 178 (description des statuts de 1340 de l'Université de Montpellier).

17. Voir Jack KEVORKIAN, *The Story of Dissection*, New York, Philosophical Library, 1959, pp. 39-41. Voir cependant, James J. WALSH, « The Popes and the History of Anatomy » (1904), *Med. Libr. and Hist. J.* 10.

18. J. KEVORKIAN, *op. cit.*, note 3, p. 189.

19. James Moore S. BALL, *The Sack-Em-Up Men: An Account of the Rise and Fall of the Modern Resurrectionist*, Londres, Oliver and Boyd, 1928, p. 40.

20. J. KEVORKIAN, *op. cit.*, note 3, p. 50.

21. Voir *infra*, ch. III, section III.B(1).

22. Voir R.-U., *Report from the Select Committee on Anatomy*, Londres, 1829, p.13 [ci-après *Select Committee on Anatomy*].

l'adoption au Canada de la loi de 1843 sur l'anatomie. Les besoins des chercheurs des facultés de médecine modernes ont ajouté à la demande. Aujourd'hui, on a besoin tous les ans de plus de six cents cadavres aux fins d'étude et d'enseignement dans les facultés de médecine[23]. Les travaux entrepris au niveau international en vue de fabriquer un cadavre électronique — dissection assistée par ordinateur, interactive et simulée — pourraient peut-être aider à répondre à la demande future dans le domaine de l'anatomie[24].

B. La demande relative aux transplantations

La transplantation courante de tissus humains est un phénomène du XX^e siècle. Depuis des dizaines d'années, les transfusions de sang et les greffes de la cornée, de la moelle osseuse et de la peau constituent des traitements usuels dans certaines situations. Les progrès de la technique ont progressivement permis des interventions plus délicates. Au cours des quinze dernières années, les transplantations d'organes ont joué un rôle de plus en plus important dans le traitement de la maladie. Il y a plus de trente ans que l'on pratique au Canada les transplantations d'organes vitaux, et cette solution est désormais considérée comme le traitement le plus indiqué dans le cas de certains patients atteints d'insuffisance rénale, cardiaque ou hépatique terminale[25]. Auparavant, ces patients se voyaient condamnés à vivre handicapés, à être longtemps malades, à dépendre d'un organe artificiel ou à mourir.

Nous verrons dans les pages qui suivent que la demande de tissus humains et d'organes découle en partie de l'évolution des diverses techniques de transplantation dans le cadre du traitement médical. Les particularités de cette évolution se révèlent parfois dramatiques parce que dans certains cas, surtout celui des greffes d'organes, l'intervention est une question de vie ou de mort. Mais chaque cas revêt également une portée générale, parce que les greffes et les transplantations de tissus et d'organes humains tendent à être régies par les mêmes principes et à susciter les mêmes difficultés.

Le succès d'une transplantation dépend, par exemple, de plusieurs facteurs : parfaite connaissance des tissus en cause, compétence du personnel et qualité des installations, compatibilité des tissus du donneur et du receveur, perfection technique, méthodes utilisées en vue de maximiser la préservation des tissus humains, choix du patient, maîtrise du rejet des tissus greffés. C'est pourquoi la découverte d'une solution à un problème fondamental permet parfois des progrès dans plusieurs types de transplantations. On peut citer, par exemple, les répercussions révolutionnaires de la cyclosporine, dont l'utilisation a entraîné

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23. Selon un sondage informel réalisé par la CRD en 1989 auprès des coroners des provinces et des responsables des programmes d'anatomie dans les facultés de médecine. La demande vient principalement de la douzaine de facultés de médecine du Québec et de l'Ontario.

24. Voir Lawrence K. ALTMAN, « Computers Create Electronic "Cadavers" for Anatomy Lessons », *New York Times* (6 septembre 1988) C3.

25. David GRANT et autres, « Experience of a Canadian Multi-Organ Transplant Service » (1986), 135:3 *Journal de l'Association médicale canadienne* 197.

la diminution du rejet de tissus greffés et l'augmentation spectaculaire du taux de réussite des greffes du foie et du cœur au cours des années quatre-vingt[26]. Des résultats préliminaires indiquent que d'autres médicaments pourraient hausser encore davantage le taux de réussite des transplantations dans les années quatre-vingt-dix[27].

À mesure qu'on surmonte les obstacles techniques, la décision de considérer une transplantation comme une expérience ou comme un traitement normal est fondée sur des critères médicaux, notamment le taux de survie, les avantages et les inconvénients des traitements de rechange, l'acceptation et la diffusion de la technique. Lorsque les transplantations franchissent le stade expérimental, la demande est susceptible d'augmenter. Ainsi, lors d'une conférence tenue au Canada en 1984 sur l'obtention et l'échange d'organes et de tissus humains, on a conclu que « [d]e nos jours, le facteur principal qui limite le nombre de transplantations est le manque d'organes et de tissus disponibles »[28]. Cet énoncé s'accorde avec les conclusions unanimes déposées par les groupes de travail fédéraux et provinciaux et les observateurs qui ont étudié la question[29]. Cinq ans plus tard, cette conclusion reste juste. Les statistiques figurant au tableau 1 indiquent le nombre de transplantations effectuées et le nombre de personnes inscrites sur les listes d'attente. Elles permettent de se faire une idée générale de l'offre et de la demande au Canada. Le nombre de transplantations pratiquées et de personnes inscrites sur les listes d'attente est plus élevé dans le cas des deux plus anciennes interventions, à savoir les greffes de la cornée et du rein. Les détails fournis au sujet de ces greffes et des autres donnent des précisions supplémentaires sur l'offre et la demande.

(1) Produits et vaisseaux sanguins

Le sang est un tissu constitué de cellules variées, en suspension dans un liquide appelé plasma[30]. Notre connaissance moderne du système circulatoire date du XVII[e] siècle et dès cette époque, des transfusions sanguines ont été tentées, sans succès[31]. Ces échecs étaient

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26. Voir en général « Proceedings of the Second International Congress on Cyclosporine: Therapeutic Use in Transplantation » (1988), 20:3 (Suppl. 3) *Transplant. Proc.*

27. Voir Thomas E. STARZL et autres, « Kidney Transplantation Under FK 506 » (1990), 264:1 *JAMA* 63.

28. SANTÉ ET BIEN-ÊTRE SOCIAL CANADA [ci-après SBSC], *Les façons de favoriser l'obtention et l'échange d'organes et de tissus humains au Canada*, Ottawa, Approvisionnements et Services Canada, 1985, p. 1.

29. Comparer « Report of the Working Group on Vital Organ Transplant Centres to the Deputy Ministers of Health » (septembre 1985) [non publié] [ci-après FEDS], 17-19 ; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, PUBLIC HEALTH SERVICE, TASK FORCE ON ORGAN TRANSPLANTATION, *Organ Transplantation: Issues and Recommendations*, Washington (D.C.), U.S. Government Printing Office, 1986, p. 27 [ci-après USTF]) (la demande d'organes excède l'offre de beaucoup). Voir TASK FORCE ON ORGAN DONATION, *Organ Donation in the Eighties: The Minister's Task Force on Kidney Donation*, Toronto, Task Force, 1985 [ci-après ONT]. Voir également Roger W. EVANS et autres, « Donor Availability as the Primary Determinant of the Future of Heart Transplantation » (1986), 255:14 *JAMA* 1892.

30. Paul R. WHEATER, H. George BURKITT et G. DANIELS, *Functional Histology*, Édimbourg, Churchill Livingstone, 1987, p. 39.

31. Voir William HARVEY, *On the Motion of the Heart and Blood in Animals*, 1628, réimpression, Chicago, Gateway, 1962.

TABLEAU 1. Quelques statistiques sur les greffes et transplantations au Canada*

Tissu ou organe	Durée maximale de préservation	Taux de survie du receveur	Centres	Nombre d'interventions par année						Liste d'attente					Coût par intervention◇
				1989	1988	1987	1986	1985	1981	12/89	12/88	12/87	12/86	12/85	
Lait	a) 1–2 jours b) 6 mois, congelé	—	19○	—	—	—	—	—	—	—	—	—	—	—	—
Sang	a) 35 jours□ b) 10 ans, congelé●	—	17●	—	—	—	—	—	—	—	—	—	—	—	—
Moelle osseuse	10 ans et plus, congelée♦	—	9	—	167	144	127	129	60	—	—	—	—	—	80 000 $
Cornée	3–4 jours	—	10	2 412	2 236	1 956	1 897	981	—	1 301	1 288	922	1 234	1 059	—
Rein	a) 24–72 h▫ b) 72 h dans la solution w/UW#	93–97% (1 an) 82–91% (5 ans)	25	858	902	826	871	737	482	1 338	1 168	1 192	939	1 027	50 000 $
Poumon	—	53,7% (1 an)	6	11 S 8 D	8 S 8 D	6 S 6 D	1 S 1 D	2 S	0	13 S 8 D	11 S 13 D	5 S 2 D	5 S 3 D	2 S	—
Foie	a) 9 h▫ b) 24–34 h dans la solution w/UW#	70% (1 an) 60% (5 ans)	10	120 A 34 E	97 A 35 E	82 A	66 A	36 A	1 A	48 A 10 E	28 A 4 E	12 A 11 E	15 A N E	34 A N E	84 000 $
Cœur	4–8 h	80% (1 an) 70% (5 ans)	11	158	185	131	123	42	1	80	52	51	50	36	83 000 $

Légende : A = adulte ; E = enfant ; D = double ; S = simple ; N = non disponible.

*Sources, sauf indication contraire : CANADIAN ORGAN REPLACEMENT REGISTER, *1988 Report* et *1989 Report*, Don Mills (Ont.), Hospital Medical Records Institute, 1990 et 1991; SANTÉ ET BIEN-ÊTRE SOCIAL CANADA.

◇Patrick SULLIVAN, « Report Raises Questions about Cost of Organ Transplantation » (1988), 139:5 *Journal de l'Association médicale canadienne* 433.

○Voir SOCIÉTÉ CANADIENNE DE PÉDIATRIE, COMITÉ SUR LA NUTRITION, « Statement on Human Milk Banking » (1985), 132:7 *Journal de l'Association médicale canadienne* 750.

□LA SOCIÉTÉ CANADIENNE DE LA CROIX-ROUGE [ci-après SCCR], *Clinical Guide to Transfusion: Products and Practices*, 2e éd., Ottawa, la Société, 1987, pp. 29–30.

●Voir SCCR, *Rapport statistique des services transfusionnels 1988-1989*, Ottawa, la Société, 1989, pp. 6-8, 10.

♦Communication personnel avec le Canadian Bone Marrow Transplant Group.

▫SBSC, « Symposium: Organ Transplantation in Canada Today » (1987), 20:1 *Annales CRMCC* 57, 58.

#Satoru TODO et autres, « Extended Preservation of Human Liver Grafts with UW Solution » (1989), 261:5 *JAMA* 711; Folkert O. BELZER et James H. SOUTHARD, « Principles of Solid Organ Preservation by Cold Storage » (1989), 45:4 *Transplant.* 673, 675.

probablement dus au fait que les transfusés recevaient du sang incompatible, ce qui peut provoquer des réactions mineures ou graves[32]. Ce n'est qu'après la découverte des quatre principaux groupes sanguins (A, B, AB et O) en 1901, et la mise au point subséquente de méthodes garantissant la compatibilité, que les transfusions sanguines sont devenues chose courante[33]. Le sang est l'un des premiers tissus à avoir été transférés avec succès entre deux humains, à des fins thérapeutiques.

Une meilleure compréhension des propriétés du sang et le développement des méthodes de préservation ont permis la constitution de réserves de sang dès la décennie précédant la Seconde Guerre mondiale[34]. Durant la guerre, la Société canadienne de la Croix-Rouge (SCCR) a assumé la plus grande partie de la responsabilité de la collecte et de la distribution du sang. Par la suite, le Canada a chargé cet organisme de recueillir et de distribuer le sang et les produits sanguins à l'échelle nationale[35].

De nos jours, les transfusions de sang sont considérées comme le « fondement de la médecine moderne » et elles ont « constitué la première transplantation d'organe »[36]. La SCCR gère dix-sept centres au Canada, d'où elle recueille, vérifie et distribue environ un million d'unités de sang chaque année[37]. Le sang recueilli est généralement séparé en globules rouges (45 %) et en plasma (55 %). Avec les globules rouges et le plasma, on peut produire les dérivés du sang, qui permettent aux hôpitaux modernes de sauver des vies humaines. Par exemple, les victimes d'accidents et les patients devant subir une intervention chirurgicale majeure doivent recevoir des transfusions sanguines, essentielles à la prévention des chocs opératoires mettant leur vie en danger. De la même manière, le traitement des grands brûlés et des hémophiles (dépourvus de l'agent normal de coagulation du sang), dépend de la transfusion de sous-produits du plasma.

Ces besoins thérapeutiques créent une demande de produits sanguins. Depuis 1981, les administrations fédérale, provinciales et territoriales se sont concertées par l'entremise du Comité canadien du sang (CCS) afin d'élaborer une politique nationale en la matière. Les principes ayant orienté le travail du Comité pendant des années ont été révisés récemment. On voulait désormais mettre l'accent sur les aspects suivants : le don volontaire ; la gratuité ou l'absence de paiement ; l'autosuffisance nationale ; l'innocuité des produits sanguins ; l'abondance et la stabilité des réserves ; le caractère national (et

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32. Voir Gilbert M. CLARK (dir.), *Legal Issues in Transfusion Medicine*, Arlington (VI), American Association of Blood Banks, 1986, p. 191.

33. Harvey G. KLEIN, « Transfusion Medicine: the Revolution of a New Discipline » (1987), 258:15 *JAMA* 2108.

34. *Ibid.*

35. RAPPORT DU COMITÉ SPÉCIAL AU COMITÉ CANADIEN DU SANG, *Étude sur le fractionnement du plasma au Canada*, Ottawa, le Comité, 1988, p. 13 [ci-après le CCS].

36. *Ibid.*

37. Voir SOCIÉTÉ CANADIENNE DE LA CROIX-ROUGE, *Rapport statistique des services transfusionnels 1988-1989*, Ottawa, la Société, 1989, pp. 6-8, 10.

non régional) du réseau ; l'efficacité et l'efficience, quant aux coûts[38]. Malgré les graves pénuries occasionnelles à l'échelle locale et l'insuffisance chronique de plasma aux fins du fractionnement, le système canadien est considéré, au sein de la communauté internationale, comme un système fondé sur le don volontaire, qui répond d'une manière générale aux besoins nationaux[39].

Indépendamment de la demande de produits sanguins comme tels, les besoins de la médecine moderne ont contribué à l'apparition d'une demande en ce qui a trait aux conduits à travers lesquels le sang circule dans le corps humain. Par exemple, des cordons ombilicaux humains traités sont greffés en remplacement de certaines veines lors de la reconstitution chirurgicale de membres gravement atteints[40].

(2) Greffes de moelle osseuse

La moelle osseuse est la substance molle qui se trouve dans la cavité intérieure des os. Elle favorise la formation des globules rouges, qui transportent l'oxygène, des globules blancs, qui attaquent les substances étrangères et infectieuses, et des plaquettes, qui jouent un rôle dans la coagulation. La greffe de moelle osseuse est utilisée depuis près de vingt-cinq ans dans le traitement des maladies telles l'anémie aplastique grave et la leucémie[41].

Dans le cas de l'anémie aplastique grave, par exemple, cette greffe est le traitement indiqué, le taux de survie à long terme atteignant environ 50 %[42]. L'anémie aplastique est une affection du sang, caractérisée par un niveau continuellement insuffisant de globules rouges. Non traitées, 80 % des victimes meurent dans les six mois suivant le diagnostic ; lorsque le malade est traité à l'aide de transfusions sanguines ou d'autres méthodes, le

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38. À compter de 1991, c'est un nouvel organisme sans but lucratif, l'Agence canadienne du sang, qui est chargée d'accomplir la mission du CCS, en se fondant sur les principes révisés. En résumé, on a repris, en leur donnant une plus grande portée et en les précisant, les quatre principes originaux, à savoir le don volontaire, la gratuité, l'autosuffisance et l'absence de but lucratif. Toutefois, le dernier est remplacé par le principe de l'efficacité et de la rentabilité — un profit limité n'est pas exclu, dans la mesure où il s'agit de satisfaire au principe de l'autosuffisance du réseau national des banques de sang. Voir le *Rapport annuel du Comité canadien du sang présenté à la Conférence provinciale-territoriale des ministres de la Santé*, Ottawa, le Comité, 1989. Voir également CCS, *op. cit.*, note 35, pp. 19-22. Comparer Organisation mondiale de la santé et Ligue des sociétés de la Croix-Rouge, « Final Recommendations of the Meeting on the Utilization and Supply of Human Blood and Blood Products (1975) », dans Piet J. HAGEN, *Blood: Gift or Merchandise*, New York, Alan R. Liss, 1982, p. 200.

39. Voir CONGRESS OF THE UNITED STATES, OFFICE OF TECHNOLOGY ASSESSMENT [ci-après OTA], *Blood Policy and Technology*, Washington (D.C.), OTA, 1985, p. 177. Voir également, *infra*, le texte accompagnant les notes 202 à 206.

40. Voir James H. THOMAS et autres, « Vascular Graft Selection » (1988), 68:4 *Surg. Clin. North Am.* 865 ; Jens H. ECKHOFF et autres, « Four Years' Results of a Prospective, Randomized Clinical Trial Comparing Polytetrafluoroethylene and Modified Human Umbilical Vein for Below-Knee Femoropopliteal Bypass » (1987), 6:5 *J. Vasc. Surg.* 506.

41. Noël A. BUSKARD, « Bone Marrow Transplantation: 25 Years of Progress » (1988), 21:7 *Ann. CRMCC* 487. Voir également Noël A. BUSKARD, « Future Directions of Bone Marrow Transplantation » (1987), 137:4 *Journal de l'Association médicale canadienne* 277.

42. Lawrence D. GROUSE et Roxanne K. YOUNG, « Bone Marrow Transplantation: A Lifesaving Applied Art » (1983), 249:18 *JAMA* 2528, 2529.

taux de survie à long terme n'est que d'environ 20 %[43]. De même, la greffe de moelle osseuse offre aux patients atteints de leucémie, un cancer des globules blancs, une meilleure chance de survie à long terme que le traitement classique fondé sur la chimiothérapie[44]. Des rapports récents indiquent même qu'entre 50 et 80 % des patients atteints de leucémie aiguë auxquels on greffe de la moelle osseuse au début de la maladie survivent de façon prolongée sans présenter les symptômes de la maladie[45]. En outre, ce traitement semble intéressant du point de vue du rapport entre le coût et l'efficacité[46].

Le manque de donneurs compatibles limite le nombre de greffes de moelle actuellement pratiquées dans les neuf centres canadiens[47]. De nombreux patients doivent compter sur un donneur apparenté (frère ou sœur, par exemple) parce que la compatibilité est meilleure, ce qui diminue d'autant le risque de rejet. Une équipe franco-américaine a récemment annoncé qu'elle avait congelé le sang du cordon ombilical d'un nouveau-né et l'avait transfusé avec succès deux semaines plus tard à son frère de cinq ans, qui souffrait d'une maladie normalement traitée par une greffe de moelle[48]. Malgré les progrès réalisés, les deux tiers environ des patients susceptibles de recevoir une greffe de moelle allogénique (moelle provenant d'une autre personne, apparentée ou non) n'en reçoivent pas en raison de l'impossibilité de trouver un donneur compatible[49]. Si l'on parvenait à en trouver, le nombre de greffes pratiquées chaque année au Canada, estimé à deux cents, pourrait doubler ou tripler[50]. Aussi la Société canadienne de la Croix-Rouge a-t-elle établi récemment un registre national en vue d'augmenter le nombre de donneurs canadiens non apparentés de moelle osseuse[51].

Le recours plus fréquent à l'autogreffe de moelle pourrait s'ajouter aux mesures visant à répondre à la demande en matière de greffes. On prélève la moelle osseuse du patient,

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43. Robert Dismore et Richard J. O'Reilly, « Bone Marrow Transplantation: Current Status » (1982), 12 *Pathobiology Annual* 213, 214.

44. Michael Barnett, Allen Eaves et Gordon Phillips, « An Overview of Bone Marrow Transplantation for Chronic Myeloid Leukemia » (1990), 143:3 *Journal de l'Association médicale canadienne* 187, 188-189. Voir aussi N.A. Buskard, *loc. cit.*, note 41, 488.

45. Voir Gail Rock et autres, « Registry of Unrelated Bone Marrow Donors » (1987), 137:3 *Journal de l'Association médicale canadienne* 294, 295.

46. Voir FEDS, *op. cit.*, note 29, p. 53. Voir également OTA, *The Cost Effectiveness of Bone Marrow Transplant Therapy and its Policy Implications*, Washington (D.C.), U.S. Government Printing Office, 1981.

47. On trouvera des projections sur le nombre de centres de 1985 à 1990 dans FEDS, *op. cit.*, note 29, p. 100.

48. Eliane Gluckman et autres, « Hematopoietic Reconstitution in a Patient with Fanconi's Anemia by Means of Umbilical-Cord Blood from an HLA-Identical Sibling » (1989), 321:17 *N. Engl. J. Med.* 1174. Voir également Jean-Yves Nau, « Les cordons de la vie », *Le Monde* (6 décembre 1989) 19.

49. N.A. Buskard, *loc. cit.*, note 41, 491.

50. Voir Société canadienne de la Croix-Rouge et le Groupe d'étude canadien sur la coopération en matière de transplantation de moelle osseuse, *Proposition en vue d'établir et de maintenir un registre canadien des donneurs volontaires de moelle osseuse*, Ottawa, la Société, 1988.

51. Voir Noël A. Buskard, « A Register of Life: The First Year of the Unrelated Bone Marrow Donor Registry » (1989), 141:6 *Journal de l'Association médicale canadienne* 600. Voir également, *infra*, le texte accompagnant la note 187.

et on la préserve ou on la congèle[52] en vue de la lui injecter après un traitement intensif de chimiothérapie[53]. L'autogreffe de moelle osseuse élimine généralement le problème de l'incompatibilité et empêche la transmission de maladies du donneur au receveur. Mais en utilisant la moelle osseuse du patient, on risque de lui réintroduire sa maladie[54]. Néanmoins, les succès signalés récemment dans divers pays donnent à penser que le recours à cette technique pourrait s'accroître[55].

(3) Greffes de la cornée

La cornée est la tunique extérieure transparente de l'œil. La greffe de la cornée (kératoplastie) vise à remplacer la cornée tellement endommagée à la suite d'une maladie ou d'un accident qu'une vision déficiente ou la cécité en découle. Les interventions expérimentales pratiquées au XIX^e^ siècle ont mené à la première greffe réussie en Europe en 1906[56]. Cependant, l'ère moderne de la kératoplastie a commencé au cours des années cinquante, avec l'avènement de meilleures techniques chirurgicales et des sutures fines, l'amélioration des méthodes de constitution de banques d'yeux et l'utilisation d'anti-inflammatoires afin de contrôler les rejets[57].

De nos jours, la greffe de la cornée est la transplantation de tissus humains le plus souvent pratiquée en Amérique du Nord, et le taux de réussite s'élève à 90 %[58]. Deux mille quatre cent douze greffes de la cornée ont été pratiquées au Canada en 1989[59]. Pourtant, la demande excède la quantité de tissus disponibles. En 1989, mille trois cent un patients étaient inscrits sur les listes d'attente dans la dizaine de centres pratiquant l'intervention au Canada[60].

(4) Greffes du rein

La première transplantation rénale a été réussie à Bostou en 1954, entre deux jumeaux identiques ; elle a inauguré l'ère de la transplantation des organes vitaux[61]. L'intervention

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52. La moelle osseuse peut être congelée pendant 13 ans. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, PUBLIC HEALTH SERVICE, NATIONAL CENTER FOR HEALTH SERVICES RESEARCH AND HEALTH CARE TECHNOLOGY ASSESSMENT, *Reassessment of Autologous Bone Marrow Transplantation*, Washington (D.C.), U.S. Government Printing Office, 1988, p. 2.

53. Voir *id.*, p. 1.

54. *Id.*, p. 12.

55. Voir *id.*, pp. 3-12.

56. COUNCIL ON SCIENTIFIC AFFAIRS, AMERICAN MEDICAL ASSOCIATION, « Report of the Organ Transplant Panel: Corneal Transplantation » (1988), 259:5 *JAMA* 719.

57. *Ibid.*

58. *Id.*, 719, 721.

59. Communication avec Santé et Bien-être Social Canada et le Canadian Ophtalmological Society Committee on Eye Banks, Subcommittee on Administrative Coordinators.

60. *Ibid.*

61. Voir Joseph E. MURRAY et J. Hartwell HARRISON, « Surgical Management of Fifty Patients with Kidney Transplants, Including Eighteen Pairs of Twins » (1963), 105 *Am. J. Sur.* 205.

a été pratiquée pour la première fois au Canada dans un hôpital de Montréal en 1958[62]. L'amélioration des techniques chirurgicales et la découverte de médicaments anti-rejet ont finalement permis à des chirurgiens de Montréal de réussir, en 1963, une greffe entre personnes non apparentées[63].

La greffe rénale constitue, aujourd'hui, le prototype des transplantations d'organes vitaux, car elle est la plus ancienne. Elle est celle qui est le plus souvent pratiquée tant au Canada qu'ailleurs dans le monde. Les chirurgiens canadiens ont effectué en 1989 environ trois fois plus de transplantations rénales que de transplantations du cœur et du foie[64]. Environ 90 % des greffés survivent un an, selon l'origine de l'organe et la thérapie anti-rejet utilisée[65]. Quand on a le choix entre la greffe et le rein artificiel, les avantages de la greffe (taux de survie comparable, coût inférieur, meilleure qualité de vie) en font d'une manière générale la solution retenue en cas d'insuffisance rénale irréversible[66]. Comme pour la greffe de la cornée, la demande est de beaucoup supérieure au nombre d'organes disponibles. En raison de cette pénurie, mille trois cent trente-huit patients attendaient une greffe dans vingt-cinq centres canadiens, à la fin de 1989[67].

(5) Greffes du cœur

En 1967, un chirurgien d'Afrique du Sud, le docteur Christian Barnard, s'est attiré l'attention du monde entier en pratiquant la première greffe cardiaque sur un humain. Le patient a survécu dix-huit jours[68]. Durant les quinze mois suivants, le nombre de greffes cardiaques pratiquées à travers le monde est monté en flèche ; la première greffe effectuée au Canada (la dix-huitième dans le monde) a été réalisée à l'Institut de cardiologie de Montréal, en 1968[69]. Toutefois, le faible taux de survie a rapidement jeté une douche froide sur l'enthousiasme initial. Au milieu des années soixante-dix, seul un petit nombre de centres à travers le monde continuaient à pratiquer ce qui était généralement considéré comme une intervention expérimentale.

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62. Mae Cox, *Human Transplants in Canada*, Edmonton (Alb.), Human Parts Banks of Canada, 1978, p. 17.

63. *Id.*, p. 18.

64. Voir Tableau 1, *supra*, p. 11.

65. *Ibid.* Comparer FEDS, *op. cit.*, note 29, p. 23 ; P.A. Keown et C.R. Stiller, « Kidney Transplantation » (1986), 66:3 *Surg. Clin. North Am.* 517, 534 ; et U.S. Department of Health and Human Services, *Report on the Scientific and Clinical Status of Organ Transplantation*, Washington (D.C.), U.S. Government Printing Office, 1988, p. 16.

66. Comparer Roger W. Evans et autres, « The Quality of Life of Patients with End-Stage Renal Disease » (1985), 312:9 *N. Engl. J. Med.* 553 et Roberta G. Simmons, Linda Abress et Carol Anderson, « Rehabilitation after Kidney Transplantation », dans G. James Cerilli (dir.), *Organ Transplantation and Replacement*, Philadelphie, J.P. Lippincott, 1988, p. 481, à la page 488.

67. Le Registre canadien des insuffisances et des transplantations d'organes, *Rapport 1989*, Don Mills (Ont.), Hospital Medical Records Institute, 1991, pp. 103, 111 [ci-après RCITO].

68. « Cardiac Transplantation » (1967), 4 *Brit. Med. J.* 757. On trouvera une analyse du problème du consentement éclairé lors de cette première greffe dans Jay Katz, *The Silent World of Doctor and Patient*, New York, Free Press, 1984.

69. M. Cox, *op. cit.*, note 62, pp. 46-47.

Durant les années quatre-vingt, des techniques chirurgicales améliorées et uniformisées, une meilleure sélection des patients et de meilleures méthodes de gestion clinique, de même que le recours à des médicaments anti-rejet, ont contribué à relever le taux de survie. Par exemple, l'utilisation de la cyclosporine a entraîné une augmentation de 10 à 15 % du taux de survie immédiate[70]. Aujourd'hui, 80 % des greffés survivent au moins un an, et 50 % survivent cinq ans[71]. Grâce à cette hausse du taux de survie, la transplantation cardiaque tend davantage à être considérée, non plus comme une méthode expérimentale, mais comme une thérapie efficace dans le cas des maladies cardiaques parvenues au stade terminal[72].

Les progrès réalisés dans ce domaine ont également favorisé une plus grande diffusion de la technologie et augmenté la demande. Le nombre de greffes a triplé depuis 1985, année où quelque cinquante interventions avaient été pratiquées[73]. À la fin de 1989, quatre-vingts patients étaient inscrits sur les listes d'attente dans huit centres au Canada[74].

(6) Greffes du foie

En 1963, à Denver (Colorado), le Docteur Thomas Starzl tentait la première greffe du foie sur un humain[75]. La première intervention canadienne du genre a été pratiquée à Calgary, onze ans plus tard[76]. La transplantation vise à remplacer un foie endommagé par suite d'une affection génétique, d'un cancer ou d'une cirrhose[77]. Malheureusement, moins de 30 % des premiers greffés ont survécu un an à l'opération, en raison du rejet de l'organe transplanté, d'hémorragies non maîtrisées, d'infections et de complications d'ordre technique[78].

Toutefois, les progrès de la médecine ont là encore modifié les piètres résultats initiaux. Les techniques de sélection des patients se sont améliorées, ainsi que les techniques chirurgicales. La découverte de la cyclosporine (médicament anti-rejet) au début des années quatre-vingt a permis de doubler et de tripler le taux de survie après un an et cinq ans[79]. Aujourd'hui, suivant l'affection à l'origine de la greffe, le taux de survie se situe à 70 %

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70. USTF, *op. cit.*, note 29, p. 18, note 4.

71. R.W. Evans et autres, *loc. cit.*, note 29, 1892.

72. Comparer FEDS, *op. cit.*, note 29, p. 19 ; et U.S. Department of Health and Human Services, *op. cit.*, note 65, p. 23.

73. Voir RCITO, *op. cit.*, note 67, p. 149.

74. En décembre 1989. Communication avec SBSC, précitée, note 59.

75. Thomas E. Starzl et autres, « Evolution of Liver Transplantation » (1982), 2:5 *Hepatology* 614.

76. M. Cox, *op. cit.*, note 62, p. 47.

77. Thomas E. Starzl et autres, « Liver Transplantation » (1989), 321:15 *N. Engl. J. Med.* 1014, 1015.

78. William J. Wall, « Liver Transplantation: Current Concepts » (1988), 139:1 *Journal de l'Association médicale canadienne* 21.

79. Voir Robert D. Gordon et autres, « Indications for Liver Transplantation in the Cyclosporine Era » (1986), 66:3 *Surg. Clinics North Am.* 541, 542-543.

et plus[80]. Comme pour les transplantations cardiaques et rénales, la hausse du taux de réussite a favorisé la diffusion de la technologie et fait augmenter la demande. Près de deux fois plus de transplantations du foie ont été pratiquées sur des adultes au Canada en 1988, que trois ans auparavant[81]. À la fin de 1989, quarante-huit adultes attendaient une greffe du foie dans les centres canadiens[82].

Plus récemment encore, on a commencé à pratiquer des transplantations du foie sur des enfants. La plupart des enfants concernés souffrent d'une maladie héréditaire connue sous le nom d'atrésie des voies biliaires, consistant dans un blocage ou une atrophie du canal cholédoque. Ce canal transporte la bile du foie vers le petit intestin. Le blocage peut causer un ictère ou mener à la cirrhose et à la mort. La chirurgie classique peut aider certains enfants, mais plus de la moitié meurent avant l'âge de deux ou trois ans[83]. Aucun centre canadien n'ayant pratiqué cette opération sur des enfants avant 1985, les pédiatres devaient auparavant diriger les malades vers des centres américains. En 1989, par contre, les chirurgiens canadiens ont pratiqué trente-quatre transplantations du foie sur des enfants ; dix enfants étaient encore inscrits sur les listes d'attente à la fin de l'année[84]. Une nouvelle technique, encore au stade expérimental, pourrait diminuer le nombre d'organes qu'il faut prélever sur des cadavres pour les greffer sur des enfants. Elle consiste à transplanter à l'enfant une partie du foie d'un adulte vivant ; le foie du donneur adulte se régénère dans le mois qui suit le prélèvement et la partie greffée se développe à mesure que l'enfant grandit[85].

(7) Greffes d'autres organes vitaux

Pour les greffes du pancréas, de l'intestin, du poumon et les greffes cœur-poumons, la demande demeure relativement modeste, en partie parce que ces nouvelles interventions sont encore largement expérimentales[86]. Par exemple, une équipe de Toronto a pratiqué la première greffe simple et la première greffe double du poumon dans le monde en 1983 et en 1986 respectivement[87]. Des chirurgiens ontariens ont pratiqué la

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80. W.J. WALL, *loc. cit.*, note 78, 21. Voir également U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, PUBLIC HEALTH SERVICE, AGENCY FOR HEALTH CARE POLICY AND RESEARCH, *Health Technology Assessment Reports, 1990: Assessment of Liver Transplantation*, Rockville (Md.), U.S. Department of Health and Human Services, 1990 [ci-après Évaluation des greffes du foie].

81. 97 c. 36. Voir Tableau 1, *supra*, p. 11.

82. SBSC, précité, note 59.

83. Diana SWIFT, « Scaled-Down Adult Livers Offer Transplant Hope to Newborns », *The Medical Post* (25 avril 1989) 11.

84. SBSC, précité, note 59.

85. Voir Russell W. STRONG et autres, « Successful Liver Transplantation from a Living Donor to Her Son » (1990), 322:21 *N. Engl. J. Med.* 1505 ; Gina KOLATA, « Surgeons Complete Historic Transplant », *New York Times* (28 novembre 1989) C10.

86. Voir U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *op. cit.*, note 65, p. 9.

87. Voir « CF Patient's Double Lung Transplant a First » (1988), 55:6 *Ont. Med. Rev.* 49 ; et R.F. GROSSMAN et autres, « Results of Single-Lung Transplantation for Bilateral Pulmonary Fibrosis » (1990), 322:11 *N. Engl. J. Med.* 727.

première transplantation du petit intestin en 1989[88]. Si ces transplantations dépassent le stade expérimental et deviennent des traitements établis, la demande augmentera vraisemblablement[89].

C. La demande relative à la biotechnologie

Dès ses débuts, l'ère de la biotechnologie a suscité, à l'égard du corps humain, de nouvelles utilisations, de nouveaux besoins et de nouveaux traitements, ainsi que de nouveaux débats[90]. Un rapport américain énumérait récemment plus de cent produits thérapeutiques actuellement en développement dans l'industrie biotechnologique, dont beaucoup sont dérivés de cellules ou de tissus humains[91]. Les progrès réalisés permettent de croire que les scientifiques pourront tirer, de certains tissus humains ayant depuis des millénaires relativement peu de valeur thérapeutique, des quantités généreuses de substances pouvant être utilisées sans risques : extraits de l'hypophyse et du pancréas, autres hormones, facteurs de coagulation du sang.

Le mot biotechnologie (contraction des mots biologie et technologie) est passé dans l'usage par suite du progrès considérable de la science de la manipulation des cellules et du matériel génétique au milieu des années 70[92]. Trois importantes techniques — la fusion cellulaire, la culture cellulaire et la technique de l'ADN recombinant — ont joué un rôle déterminant dans l'application de la biotechnologie à la médecine. La technique de l'ADN recombinant consiste dans l'obtention, par combinaison de fragments hétérologues, de l'acide désoxyribonucléique (ADN), la molécule porteuse des caractères génétiques de la cellule ; cette molécule contient les instructions programmées qui définissent les composantes de la cellule et la façon de les fabriquer[93]. Dans le clonage des gènes (technique de l'ADN recombinant), on isole certains fragments de l'ADN d'une cellule, qu'on transfère dans une autre cellule, de manière à ce que la cellule receveuse puisse, à mesure qu'elle croît, produire et exprimer la composition génétique de la cellule originale[94].

Les techniques de la fusion et de la culture cellulaire visent également à manipuler la croissance des cellules. La fusion cellulaire, qui consiste dans le croisement de cellules provenant d'espèces différentes, peut produire des cellules hybrides immortelles appelées

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88. Cameron JOHNSTON, « Canadian Surgeons Lay Claim to World's First Successful Bowel Transplant » (1989), 141:2 *Journal de l'Association médicale canadienne* 156.

89. Voir FEDS, *op. cit.*, note 29, pp. 36-38.

90. Voir *infra*, ch. III.

91. OTA, *New Developments in Biotechnology: Ownership of Human Tissues and Cells*, document rédigé par Gladys B. WHITE et autres, Washington (D.C.), U.S. Government Printing Office, 1987, pp. 56-59 [ci-après G.B. WHITE].

92. A. CRAFTS-LIGHTY, *Information Sources in Biotechnology*, New York, Nature Press, 1983, p. 1.

93. G.B. WHITE, *op. cit.*, note 91, p. 41.

94. BEAK CONSULTANTS, *Questions de réglementation concernant la biotechnologie au Canada*, Mississauga (Ont.), Beak Consultants, 1987, p. 1.1.

hybridomes[95]. Pour obtenir en grande quantité des cellules génétiquement différentes pouvant être fusionnées, les biotechnologues ont amélioré le très ancien procédé de la culture cellulaire, soit la culture de cellules vivantes, comme pour la fabrication du fromage et du yaourt. L'application moderne consiste à cultiver des cellules issues de tissus humains de manière à ce qu'elles se multiplient en se copiant à l'infini, créant ainsi une lignée cellulaire[96].

Tirer parti de ces techniques pour obtenir des produits thérapeutiques n'est pas une mince tâche, mais certaines sociétés ont réussi à faire bénéficier la médecine des fruits de la recherche biotechnologique effectuée en laboratoire. Déjà, les autorités fédérales canadiennes ont autorisé l'utilisation de certaines substances fabriquées génétiquement : le vaccin contre l'hépatite B, l'insuline, et un médicament contre le cancer, l'interféron[97]. On est à mettre au point des vaccins dérivés de l'ADN recombinant en vue de combattre la polio et des maladies transmises sexuellement[98]. Des facteurs de croissance dérivés de l'ADN et de la fusion cellulaire ont fait l'objet d'essais cliniques dans le cadre des nouvelles techniques de greffe de la moelle osseuse[99]. Par ailleurs, l'emploi du facteur VIII recombinant dans le traitement des hémophiles devrait recevoir le feu vert des autorités fédérales au cours de l'année 1991-1992.

La mise au point de l'un de ces produits — l'hormone de croissance humaine — montre les répercussions possibles de la biotechnologie sur la médecine et le droit. Le corps humain fabrique des hormones en si petite quantité que leur extraction exige d'énormes quantités de tissus humains, ou s'avère tout simplement impossible[100]. Par exemple, l'insuline produite par les cellules du pancréas n'est pas prélevée sur les cadavres parce que la concentration d'hormones est trop faible. Par conséquent, le traitement des diabétiques a traditionnellement reposé sur l'insuline extraite du pancréas des porcs et des moutons, qui a cependant parfois des effets indésirables sur la santé des humains[101].

Par contre, l'hormone de croissance humaine (HCH) a traditionnellement été tirée des cellules de l'hypophyse humaine. L'HCH est utilisée pour traiter le nanisme, anomalie causée par une insuffisance hypophysaire. Au Canada, le traitement de centaines d'enfants est fondé depuis des années sur un programme national dans le cadre duquel on prélève des glandes pituitaires sur des cadavres, que l'on pulvérise pour en extraire la précieuse hormone de croissance[102]. La possibilité d'obtenir des hypophyses humaines constitue

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95. G.B. WHITE, *op. cit.*, note 91, p. 5.

96. *Id.*, p. 33.

97. Communication avec la Direction des médicaments de SBSC. Voir également OTA, *Commercial Biotechnology: An International Analysis*, Washington (D.C.), OTA, 1984, ch. V, p. 119.

98. Voir OTA, *op. cit.*, note 97, pp. 143 et 144.

99. BEAK CONSULTANTS, *op. cit.*, note 94, p. 3.12. Voir également Harold M. SCHMECK, « Cell Growth Factors Emerge as Potent Therapies », *New York Times* (28 mars 1989) C1.

100. Voir Ronald W. ELLIS, « Vaccines, Diagnostic Proteins and Hormones », dans H. REHM et G. REED (dir.), *Biotechnology*, vol. 7B, New York, VCH Publishers, 1989, p. 167, aux pages 170-171.

101. Voir BEAK CONSULTANTS, *op. cit.*, note 94, p. 3.12.

102. Voir « Conclusion réussie de l'essai de 20 ans du CRM sur l'hormone de croissance » (1988), 17:2 *Actualités* 7,8.

évidemment un facteur déterminant pour l'administration de l'hormone[103]. Aussi plusieurs provinces ont-elles adopté des textes législatifs créant une présomption de consentement, de manière à faciliter les prélèvements en vue de l'application du programme[104].

Or récemment, ce programme national a subi une transformation fondamentale. Entre 1985 et 1987, deux raisons ont amené la plupart des pédiatres canadiens à cesser d'utiliser l'hormone prélevée sur des cadavres pour se servir à la place de l'HCH dérivée de l'ADN recombinant. Premièrement, on a soulevé, dans la communauté médicale internationale, l'hypothèse selon laquelle le décès de certains patients aurait été causé par l'injection d'HCH contaminée provenant de cadavres ; deuxièmement, on a entrepris des essais cliniques au Canada en vue de vérifier l'efficacité de l'HCH dérivée de l'ADN recombinant[105]. Cela a incité les autorités et les médecins canadiens à accélérer les essais cliniques, d'où l'attribution, en 1986, de permis pour l'administration de cette substance, aujourd'hui utilisée au Canada. Ce changement rend sans doute inutiles les textes établissant une présomption de consentement, pour le prélèvement d'hypophyses sur des cadavres.

II. Les sources de tissus et de substances thérapeutiques

Les humains fournissent la plupart des tissus et des parties du corps nécessaires aux transplantations et aux greffes. Les animaux, les produits artificiels et synthétiques et les banques de tissus constituent toutefois d'autres sources.

A. Les animaux

Les animaux remplissent actuellement trois fonctions importantes dans le domaine de la transplantation des tissus. Premièrement, la société a depuis longtemps utilisé les animaux comme sujets de laboratoire afin d'élaborer et de perfectionner les techniques expérimentales et chirurgicales qui seront plus tard appliquées aux humains. Les greffes du foie, par exemple, ont été précédées de dizaines d'années de travail sur des animaux en laboratoire[106]. Deuxièmement, le traitement de certains patients dépend d'hormones provenant d'animaux. Exemple classique : l'insuline administrée aux diabétiques. Troisièmement, des tissus provenant d'animaux servent à des greffes temporaires et

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103. Charles McLean et autres, « The Extraction, Purification and Synthesis of Anterior Pituitary Hormones for Therapeutic and Diagnostic Use », dans Colin Beardwell et Gary L. Robertson (dir.), *The Pituitary*, Londres, Butterworths, 1981, p. 238, à la p. 239.

104. Voir le texte accompagnant la note 845, *infra*.

105. Voir *Actualités*, *loc. cit*, note 102. Voir également P. Brown, « Human Growth Hormone Therapy and Creutzfeldt-Jakob Disease: A Drama in Three Acts » (1988), 81:1 *Pediatrics* 85. La possibilité d'obtenir l'HCH par recombinaison génétique a apparemment soulevé de nouvelles inquiétudes d'ordre éthique et économique. Voir John Lantos, Mark Siegler et Leona Cuttler, « Ethical Issues in Growth Hormone Therapy » (1989), 261:17 *JAMA* 1020.

106. Voir, par exemple, T.E. Starzl, *loc. cit.*, note 75, 614-615.

permanentes : utilisation du catgut comme sutures absorbables, des valves du cœur de porcs pour la chirurgie cardiaque[107], ou de la peau des porcs et de l'amnios des bovins comme bandages biologiques[108] dans le traitement des brûlures.

Devrait-on greffer à des humains des organes prélevés sur des animaux ? La réponse à cette question est liée à la recherche médicale ainsi qu'à des considérations d'ordre éthique et juridique connexes. Le problème s'est présenté concrètement en 1984, lorsqu'un chirurgien californien a tenté une hétérogreffe sur « bébé Fae ». L'idée remonterait à la préhistoire ; on a commencé à pratiquer des hétérogreffes durant les années 1900 (utilisation de reins prélevés sur des lapins, des porcs et des moutons)[109]. Les progrès réalisés dans le domaine de la transplantation rénale au début des années soixante ont relancé l'idée de la transplantation d'organes vitaux prélevés sur des primates[110]. Le cas « bébé Fae » marque la première transplantation d'un cœur de babouin à un enfant souffrant d'une malformation cardiaque rare, qui entraîne habituellement la mort durant le mois suivant la naissance[111]. Bébé Fae a survécu vingt jours avant que son organisme ne rejette l'organe étranger[112].

Cette affaire a soulevé d'énormes controverses :

- L'établissement concerné avait-il respecté les lois fédérales régissant les recherches de ce genre[113] ?
- Existait-il un espoir raisonnable que bébé Fae bénéficie de l'intervention, ou a-t-elle simplement été un instrument de recherche pour la science[114] ?
- Les parents étaient-ils en mesure de donner un consentement éclairé, compte tenu du fait qu'on a peut-être exagéré les chances de survie, et minimisé la possibilité d'obtenir un cœur humain[115] ?

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107. Voir Peter Bloomfied et autres, « Twelve-Year Comparison of a Bjork-Shiley Mechanical Heart Valve with Porcine Bioprostheses » (1991), 324:9 *N. Engl. J. Med.* 573.

108. Voir Arnold Luterman et P. William Curreri, « Skin Transplantation », dans G.J. Cerilli (dir.), *op. cit.*, note 66. Voir également A.S. Brown et L.R. Barot, « Biologic Dressings and Skin Substitutes » (1986), 13:1 *Clinics in Plastic Surgery* 69.

109. Council on Scientific Affairs, American Medical Association, « Xenografts: Review of the Literature and Current Status » (1985), 254:23 *JAMA* 3353.

110. *Ibid.*

111. L.L. Bailey et autres, « Baboon-to-Human Cardiac Xenotrans-plantation in a Neonate » (1985), 254:23 *JAMA* 3321.

112. *Ibid.*

113. Voir 45 C.F.R., art. 46.

114. Robert M. Veatch, « The Ethics of Xenografts » (1986), 18:3 (Suppl. 2) *Transplant. Proc.* 93.

115. Voir U.S. Department of Health and Human Services, National Institute of Health, *Report of the National Institute of Health Site Visit*, Washington (D.C.), U.S. Government Printing Office, 1986, pp. 5-6. Voir également George J. Annas, « Baby Fae: The "Anything Goes" School of Human Experimentation » (1985), 15:1 *Hast. Cent. Rep.* 15, 16.

- Les hétérogreffes constituent-elles une atteinte à la loi de la nature ou un manque de respect à l'égard des autres espèces, réduisant les animaux à de simples instruments au service du bien-être des humains[116] ?
- Y a-t-il lieu d'affecter des ressources publiques à de telles expériences médicales, même lorsqu'il n'existe aucune thérapie de rechange acceptable[117] ?

L'approbation d'une telle intervention dans une université canadienne dépendrait du résultat des délibérations et des protocoles de recherche des comités d'éthique de l'établissement[118]. L'affaire « bébé Fae » démontre que ces recherches médicales suscitent d'épineux problèmes d'ordre éthique et juridique, qui justifient vraisemblablement un examen attentif et certaines interdictions. Mais une prohibition permanente risquerait de priver les Canadiens de toute possibilité de recours thérapeutique aux hétérogreffes.

B. Les humains

Les tissus nécessaires aux greffes et aux transplantations proviennent surtout des humains. Les sources de tissus peuvent être classées comme suit : les excrétions ou leurs sous-produits, notamment la sueur, l'urine, les suites de l'accouchement ; les substances et les tissus susceptibles de régénération — peau, lait, sang, moelle osseuse, etc. ; les organes non susceptibles de régénération — cœur, reins ou foie, par exemple — et enfin le corps entier ou les cadavres[119]. Les cheveux et les dents peuvent déborder les catégories définies ou ne pas facilement entrer dans celles-ci. Malgré tout, cette catégorisation s'avère parfois importante. Pour le don de tissus susceptibles de régénération, par exemple, le risque médical et l'atteinte à l'intégrité physique sont faibles, en général[120].

Par contre, les tissus et les organes non susceptibles de régénération sont prélevés sur des donneurs adultes décédés — sur des cadavres, donc. La transplantation du rein d'un donneur vivant constitue une exception notable. Les donneurs vivants de reins représentaient quelque 15 % des donneurs au Canada en 1989[121]. Les bébés et les enfants

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116. R.M. VEATCH, *loc. cit.*, note 114, 94. Voir également Scrachan DONNELLEY et Williard GAYLIN, « Case Studies: The Heart of the Matter » (1989), 19:1 *Hast. Cent. Rep.* 26. On trouvera des réflexions sur les crimes contre les animaux dans CRD, *Pour une nouvelle codification du droit pénal — édition révisée et augmentée du Rapport n° 30*, Rapport n° 31, Ottawa, la Commission, 1987, p. 110-111.

117. A.L. Caplan, « Ethical Issues Raised by Research Involving Xenografts », (1985) 254:23 *JAMA* 3339, 3342.

118. Voir CONSEIL DE RECHERCHES MÉDICALES DU CANADA, *Lignes directrices concernant la recherche sur des sujets humains*, Ottawa, Approvisionnements et Services Canada, 1987, p. 19 [ci-après CRMC]. Pour la jurisprudence concernant la recherche sur des sujets humains, voir *infra*, note 376.

119. Voir Michèle HARICHAUX, « Le Corps Objet », dans Raphaël DRAÏ et Michèle HARICHAUX (dir.), *Bioéthique et Droit*, Paris, PUF, 1988, p. 130, aux pages 132-136.

120. Voir cependant *Cox* c. *Saskatoon*, [1942] 1 W.W.R. 717 (C.A. Sask.) (dommages-intérêts accordés au donneur, à cause d'une infection découlant de la transfusion).

121. 138 sur 902. Voir RCITO, *op. cit.*, note 67. Le chiffre de 15 % concorde avec celui des années précédentes, ainsi qu'avec la proportion de 20 % aux États-Unis. Voir *Registre canadien de l'insuffisance rénale : rapport de 1986*, Ottawa, Fondation canadienne des maladies du rein, 1987, p. 115 [ci-après RCIR] ; et U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *op. cit.*, note 65, p. 14. Voir en général, Peter G. BLAKE et Carl J. CARDELLA, « Kidney Donation by Living Unrelated Donors » (1988), 141:8 *Journal de l'Association médicale canadienne* 773.

peuvent également être des donneurs d'organes de leur vivant, mais leur capacité de consentir à un don et leur vulnérabilité particulière suscitent des préoccupations spéciales d'ordre juridique et éthique[122].

C. Les sources artificielles et synthétiques

Les prothèses artificielles et synthétiques servant à remplacer certaines parties du corps humain sont utilisées depuis longtemps dans le traitement des maladies et des blessures. Il y a plusieurs siècles déjà, on fabriquait des membres artificiels afin de remplacer les bras et les jambes souvent perdus au combat. Les fausses dents ont été utilisées dès le VII^e siècle av. J.-C. ; sous leur forme moderne, elles remontent au XVIII^e ou au XIX^e siècle et elles étaient destinées à remplacer la transplantation de dents prélevées sur des donneurs vivants et le commerce occasionnel des dents prélevées sur les cadavres laissés sur les champs de bataille[123]. Aujourd'hui, la technique permet de fabriquer des vaisseaux sanguins synthétiques et des valves cardiaques mécaniques, ou encore de produire par recombinaison génétique de l'insuline (hormone produite par le pancréas humain). Les lentilles synthétiques, les yeux artificiels et les appareils auditifs électroniques sont désormais monnaie courante. Par contre, les appareils destinés à remplacer les poumons, le cœur, le foie ou le pancréas constituent des réalisations plus récentes et plus complexes[124]. En effet, peu d'organes artificiels sûrs et efficaces ont fait l'objet de permis délivrés en vertu des lois fédérales canadiennes. Le succès mitigé du cœur artificiel illustre la règle, tandis que l'utilisation répandue du rein artificiel constitue l'exception.

(1) Rein artificiel

Le rein artificiel (dialyse rénale) est le seul organe artificiel qui relève de la thérapie courante lorsqu'il y a cessation irréversible des fonctions rénales. Après des dizaines d'années de recherche, d'expériences et de perfectionnement, la dialyse à long terme a commencé à être pratiquée durant les années soixante[125]. Aujourd'hui, cette technique offre un traitement sûr et efficace en cas de cessation irréversible des fonctions rénales due à des causes diverses. En 1989, par exemple, quelque cinq mille six cents patients recevaient des traitements de dialyse dans un grand nombre de centres à travers le Canada[126].

Le traitement impose des restrictions à la qualité de la vie. Il exige en effet généralement trois visites par semaine à un centre de dialyse. Chaque séance dure entre trois et

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122. Voir *infra*, ch. II et III.

123. Jeanne THOMAS, « Fangs for the Memories: False Teeth Have Come a Long Way Over Century », *The Medical Post* (11 avril 1989) 71.

124. Voir Harold M. SCHMECK, *The Semi-Artificial Man*, New York, Walker, 1965.

125. Voir William DRUKKER, « Haemodialysis: A Historical Review », dans William DRUKKER, Frank M. PARSONS et John F. MAHER (dir.), *Replacement of Renal Function by Dialysis*, 2^e éd., Boston, Martinus Nijhoff, 1983, p. 3, à la page 28.

126. RCITO, *op. cit.*, note 67, pp. 5, 157.

cinq heures, et les patients sont astreints à une diète sévère. La transplantation rénale était exclue pour environ 40 % des patients qui suivaient des traitements de dialyse en 1986[127], en raison de leur âge ou pour des raisons médicales[128].

Parce que le rein artificiel est le seul organe vital artificiel non expérimental, il joue un rôle unique en cas d'échec de la transplantation. Les greffés dont l'opération a échoué (c'est une minorité) ont, en théorie, deux possibilités : une nouvelle transplantation ou un rein artificiel. Les receveurs d'autres organes vitaux font statistiquement face à des risques plus grands d'échec de la transplantation[129]. Et en cas d'échec, aucun organe artificiel sûr et efficace n'est disponible en attendant une autre transplantation.

(2) Cœur artificiel

L'utilisation thérapeutique du cœur artificiel est moins avancée. Certains appareils visant à parer à l'insuffisance cardiaque, notamment le stimulateur cardiaque ainsi que les valves synthétiques et mécaniques mises au point au cours des années soixante, font désormais partie du traitement normal[130]. L'implantation d'un cœur artificiel, par contre, revêt encore un caractère expérimental[131]. Ce traitement n'offre donc aux patients ni la sécurité, ni la qualité de vie qu'assure la dialyse rénale. Les patients utilisant un cœur artificiel font face à des risques de caillots sanguins et d'infections, et leur qualité de vie est diminuée[132].

Dans les quelques hôpitaux canadiens ayant recours au cœur artificiel, l'appareil sert de « pont temporaire » avant la transplantation cardiaque. Cet usage s'est répandu après des tentatives d'implanter un cœur artificiel permanent sur cinq patients américains, au début des années quatre-vingt[133]. L'intervention a permis à certains patients de se déplacer et de reprendre certaines activités pour une période allant de 10 à 620 jours[134]. Toutefois, la qualité de vie de ces patients a été compromise par de graves accidents cérébrovasculaires, des infections chroniques et des séjours répétés à l'hôpital[135]. L'appareil continue à soulever de grands débats d'ordre éthique[136].

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127. RCIR, *op. cit.*, note 121, pp. 119, 131-132 (1 506 des 3 484 patients enregistrés, soit 43 %, ne pouvaient recevoir une transplantation pour des raisons médicales).

128. OTA, *Life-Sustaining Technologies and the Elderly*, Washington (D.C.), OTA, 1987, p. 249.

129. Voir Tableau 1, *supra*, p. 11.

130. Voir Wilfred LYNCH, *Implants: Reconstructing the Human Body*, New York, Van Nostrand Reinhold, 1982, pp. 52, 75.

131. Comme il s'agit d'un appareil expérimental, son utilisation est régie par des lignes directrices fédérales concernant la recherche et par la législation fédérale relative aux appareils médicaux. Voir CRMC, *op. cit.*, note 118, p. 19. Voir également *infra*, ch. III.

132. Voir Steven H. MILES et autres, « The Total Artificial Heart: An Ethics Perspective on Current Clinical Research and Deployment » (1988), 94:2 *Chest* 409.

133. Voir Gideon GIL, « The Artificial Heart Juggernaut » (1989), 19:2 *Hast. Cent. Rep.* 24.

134. William C. DEVRIES, « The Permanent Artificial Heart » (1988), 259:6 *JAMA* 849.

135. *Ibid.*

136. Voir S.H. MILES et autres, *loc. cit.*, note 132. Comparer George J. ANNAS, « Death and the Magic Machine: Informed Consent to the Artificial Heart » (1987), 9 *W. New Eng. L. Rev.* 89 ; et U.S. DEPARTMENT OF

(3) Fabrication de cellules, de tissus humains et de médicaments par les techniques du génie génétique

Il a été question plus haut de la fabrication, par les techniques du génie génétique, de diverses substances : insuline, médicaments anticancéreux, hormone de croissance humaine, facteurs de coagulation du sang ; des progrès ont en outre été réalisés dans la fabrication synthétique de certains organes : peau, veines, glandes, valves, et dans certains cas on a déjà atteint le stade de l'utilisation thérapeutique[137]. La recherche en cours sur l'obtention des facteurs de croissance des cellules par l'ADN recombinant montre par ailleurs comment la nouvelle technologie du remplacement des tissus humains peu aider à diminuer la demande en ce qui a trait aux tissus humains thérapeutiques difficiles à trouver. Les facteurs de croissance des cellules fabriqués par les techniques du génie génétique copient et propagent les substances favorisant la croissance produites naturellement dans le corps humain. Ces facteurs devraient être utilisés dans le cadre de plusieurs traitements, de l'inhibition des cellules cancéreuses aux transplantations de la moelle osseuse[138].

Par exemple, on a récemment étudié, lors d'essais cliniques, l'utilisation des facteurs de croissance pour stimuler la production de globules rouges dans le traitement de l'anémie, une déficience de ces globules. Les patients en dialyse rénale et les greffés du rein ont souvent besoin de nombreuses transfusions de sang afin de traiter leur anémie, un des effets secondaires de l'insuffisance rénale. Les scientifiques ont constaté que l'augmentation du nombre de globules rouges après l'absorption de l'hormone érythropoïétine fabriquée génétiquement tendait à réduire le nombre de transfusions nécessaires, améliorant par le fait même la qualité de vie des patients[139]. Les autorités fédérales américaines et canadiennes compétentes ont reconnu en 1989-1990 que l'érythropoïétine est une substance sûre et efficace[140].

HEALTH AND HUMAN SERVICES, WORKING GROUP ON MECHANICAL CIRCULATORY SUPPORT OF THE NATIONAL HEART, LUNG, AND BLOOD INSTITUTE, *Artificial Heart and Assist Devices: Directions, Needs, Costs, Societal and Ethical Issues*, Washington (D.C.), National Institute of Health, 1985.

137. Voir P. BLOOMFIELD et autres, *loc. cit.*, note 107 ; le texte accompagnant les notes 97 à 105, *supra*; *infra*, note 206 et le Tableau 2, *infra*, p. 141, ch. III. Voir aussi E. BELL et M. ROSENBERG, « The Commercial Use of Cultivated Human Cells » (1990), 22:3 *Transplant. Proc.* 971 ; Lawrence M. FISHER, « 3 Companies Speed Artificial Skin », *New York Times* (12 septembre 1990) D1, et « Biomatériaux : l'avenir de l'homme-prothèse », *Le Monde* (5 septembre 1990) 25.

138. Voir Michael B. SPORN et Anita B. ROBERTS, *Peptide Growth Factors and Their Receptors*, New York, Springer-Verlag, 1990.

139. Voir Joseph W. ESCHBACH et autres, « Treatment of the Anemia of Progressive Renal Failure with Recombinant Human Erythropoietin » (1989), 321:3 *N. Engl. J. Med.* 158.

140. Voir Rhonda L. RUNDLE, « Biotech Battlefront: Amgen, Cleared to Sell Kidney Patient Drug, Still Faces Big Hurdles », *Wall Street Journal* (2 juin 1989) A1. Pour une discussion concernant les litiges entre les sociétés américaines de biotechnologie au sujet du brevet relatif à l'EPO, voir également *Amgen Inc.* c. *Chugai Pharmaceutical Co.*, *infra*, note 776.

D. Préservation des tissus et constitution de banques

Lorsqu'un tissu humain est prélevé du corps, il est privé de sang et des éléments nutritifs essentiels, de même que de l'oxygène transporté par le sang, ce qui entraîne normalement la mort ou la détérioration de ce tissu. La préservation des tissus humains vise à suspendre ce processus dégénératif. La science médicale permet ainsi de congeler et de préserver grâce à des procédés chimiques les tissus aux fins de traitement et de recherche[141].

Comme dans le cas de la technologie de la transplantation, la science médicale a commencé à maîtriser la conservation de tissus thérapeutiques simples avant de mettre au point des méthodes pour la préservation des reins, d'autres tissus complexes ainsi que des organes vitaux. Ces techniques sont dans une large mesure postérieures à la Seconde Guerre mondiale, le point de départ consistant dans la mise au point de la conservation du sang durant les années quarante[142]. Depuis, les progrès réalisés ont permis de conserver certaines substances susceptibles de régénération, notamment le sang, le sperme, la peau, la moelle osseuse, les cellules et le lait prélevés sur des donneurs vivants, ainsi que des tissus non susceptibles de régénération — valves du cœur, veines, tendons, nerfs, os, tissus cornéens — prélevés sur des cadavres[143]. Actuellement, les banques de tissus varient en taille et en complexité ; certaines sont des centres complets alors que d'autres sont des petites entreprises locales offrant un type de tissu à un médecin en particulier et fonctionnant sous la responsabilité de celui-ci[144].

Malheureusement, il n'existe pas encore de banques de foies, de reins et de cœurs. Dans l'état actuel de la technique de transplantation, ces organes vitaux nécessitent une perfusion de sang presque continue pour empêcher leur détérioration. Avec les solutions habituelles de conservation, les chirurgiens disposent généralement de quelques heures — et d'au plus quelques jours — entre le prélèvement de l'organe sur un donneur et son implantation dans le corps du receveur[145]. Une nouvelle solution de préservation chimique, récemment approuvée, la solution UW, pourrait doubler ou tripler le délai à la disposition du chirurgien pour greffer l'organe[146]. Il demeure que, vu la différence avec les délais plus longs régissant le prélèvement de tissus humains, la courte période dont dispose le chirurgien pour pratiquer la transplantation et l'absence de régénération des organes vitaux, la recherche de receveurs et la transplantation des organes disponibles doivent se faire rapidement et correctement.

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141. Voir R. RAZABONI et W.W. SHAW, « Preservation of Tissue for Transplantation and Replantation » (1983), 10:1 *Clinics in Plastic Surgery* 211, 212-213.

142. Voir, *supra*, le texte accompagnant les notes 33 à 35.

143. Voir *Report of the Alberta Human Tissue Procurement Task Force*, Edmonton (Alb.), Task Force, 1985, p. 24.

144. *Ibid.*

145. Voir Tableau 1, *supra*, p. 11.

146. Voir *ibid.* Voir également Satoru TODO et autres, « Extended Preservation of Human Liver Grafts with UW Solution » (1989), 261:5 *JAMA* 711 ; Folkert O. BELZER et James H. SOUTHARD, « Principles of Solid Organ Preservation by Cold Storage » (1988), 45:4 *Transplant.* 673, 675.

Banques de lait : Le lait est l'une des premières substances du corps humain à avoir été recueillies à des fins thérapeutiques. La première banque canadienne de lait a été établie durant les années vingt au Children's Hospital de Winnipeg[147]. Au milieu des années quatre-vingt, on comptait environ vingt banques de lait[148]. Ces banques fournissent du lait maternel aux enfants qui ne sont pas en mesure d'en recevoir suffisamment de leur mère[149]. Dans certains pays, les femmes sont payées lorsqu'elles font des dons de lait dans des supermarchés faisant office de centres de distribution, mais au Canada, les mères sont encouragées à donner gratuitement leur lait aux banques situées dans les hôpitaux[150]. Le lait peut être réfrigéré pendant 24 à 48 heures, ou congelé pendant une période maximale de six mois[151].

Banques de sang : La constitution de réserves de sang est maintenant tout à fait courante, et la technique s'est perfectionnée depuis les débuts, dans les années quarante[152]. La durée de conservation du sang devant servir à des fins thérapeutiques dépend du produit sanguin. Le sang entier peut être réfrigéré pendant quelque trente-cinq jours, le plasma congelé se conserve de trois à douze mois et les globules rouges congelés peuvent être conservés pendant dix ans[153]. On compte environ neuf cents banques de sang au Canada — le recours aux techniques de conservation de cette substance est plus courant et plus fréquent que pour tout autre organe ou tissu[154].

Banques d'yeux : La première banque d'yeux canadienne a été mise sur pied à l'Université de Toronto en 1955[155]. De nos jours, dix banques d'yeux offrent leurs

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147. Gilbert SHARPE, *The Law & Medicine in Canada*, 2e éd., Toronto, Butterworths, 1987, p. 330.

148. Voir SOCIÉTÉ CANADIENNE DE PÉDIATRIE, COMITÉ SUR LA NUTRITION, « Statement on Human Milk Banking » (1985), 132:7 *Journal de l'Association médicale canadienne* 750.

149. R.S. SAUVÉ et autres, « Mothers' Milk Banking: Microbiologic Aspects » (1984), 75 *Can. J. Public Health* 133.

150. Mentionnons cependant les résultats d'une enquête réalisée en 1981, révélant qu'une banque canadienne rémunérait les donneuses, et le cas de la Finlande, où l'on paie 20 $ le litre. Voir CALGARY MOTHERS' MILK BANK, *Mothers' Milk Bank Manual*, Calgary (Alb.), Calgary Mothers' Milk Bank, 1984, p. 5 et Martti A. SIIMES et Niilo HALLMAN, « A Perspective on Human Milk Banking 1978 » (1979), 94:1 *J. Pediatr.* 173. Une communication personnelle avec le professeur Siimes révèle que la somme de 13 $ le litre payé en 1977 a été portée à 20 $ le litre.

151. SBSC, *Guide de prévention des infections pour les soins périnatals*, Ottawa, SBSC, 1988, p. 12 ; SBSC, *Les soins à la mère et au nouveau-né dans une perspective familiale : lignes directrices nationales*, Ottawa, Approvisionnements et Services Canada, 1987, par. 7.11, pp. 79-80. Au Canada, les banques de lait sont généralement régies par des lignes directrices élaborées par des professionnels, mais d'autres pays ont adopté des textes législatifs et réglementaires à ce sujet. Voir, par exemple, *N.Y. Pub. Health Law*, art. 2505 et 4360 (McKinney, 1991 Supp.), et les règlements français sur les banques de lait, *infra*, note 935.

152. Voir *supra*, section 1.B(1).

153. Voir CCS, *op. cit.*, note 35, p. 34, où l'on cite SCCR, *Guide de la pratique transfusionnelle*, 2e éd., Ottawa, la Société, 1987, p. 29.

154. Une banque par dix centres de transfusion de la SCCR, et une banque dans chacun des 882 hôpitaux ayant reçu des produits sanguins distribués par la SCCR durant l'année 1988-1989. Voir *Rapport statistique des services transfusionnels*, *op. cit.*, note 37, p. 58.

155. Voir Anne WOLFE, *The Eye Bank of Canada 1951 to 1988* [non publié], p. 1.

services à travers le Canada. Les cornées, prélevées sur des donneurs décédés, sont réfrigérées dans une solution tissulaire où elles pourront être préservées de trois à quatre jours[156]. Certaines banques congèlent les cornées pour transplantation future. Toutefois, comme la plupart des banques canadiennes d'yeux utilisent la méthode de la réfrigération pendant trois ou quatre jours, elle jouent le rôle de centres de cueillette, de calibrage et de distribution de cornées fraîches[157]. Entre avril 1988 et mars 1989, les banques d'yeux du Canada ont prélevé, conservé ou distribué plus de cinq mille yeux ; environ six cents ont été conservés dans des solutions de longue durée ou traités et conservés pour être utilisées à titre de lentilles cornéennes vivantes ; mille huit cents ont servi à la recherche et à l'enseignement, et deux mille trois cents ont été transplantés[158].

Banques de sperme : Le sperme humain peut être congelé et conservé durant des années avant d'être décongélé et utilisé dans le traitement de l'infertilité. Les premières grossesses réussies à l'aide de sperme congelé ont été signalées durant les années cinquante[159]. L'insémination artificielle a fait ses débuts au Canada à la fin des années soixante[160]. Sur les onze centre canadiens d'insémination artificielle ayant répondu à une enquête réalisée au début des années quatre-vingt (on s'était adressé à dix-huit centres en tout), trois ont déclaré utiliser régulièrement du sperme congelé, alors que les huit autres centres utilisaient du sperme frais[161]. Aujourd'hui, l'insémination artificielle est une « pratique courante, à la fois avec du sperme frais et avec du sperme congelé.[162] » L'utilisation de sperme congelé semble être plus courante dans certains autres pays[163], mais des inquiétudes concernant les risques de transmission du VIH ont récemment poussé certains Canadiens à exiger l'utilisation obligatoire et exclusive de sperme congelé, qui permet un dépistage plus efficace[164]. La congélation d'autres tissus reproductifs commence également à être utilisée dans le traitement de l'infertilité[165].

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156. Voir COUNCIL ON SCIENTIFIC AFFAIRS, *loc. cit.*, note 56, 720.

157. Voir COMMISSION MANITOBAINE DE RÉFORME DU DROIT, *Report on the Human Tissue Act*, Rapport n° 66, Winnipeg, la Commission, 1986, p. 5 ; M. COX, *op. cit.*, note 62, p. 10.

158. Des 2 342 cornées transplantées, 301 étaient fraîches, utilisées généralement dans les vingt-quatre heures du prélèvement, 1 994 avaient été réfrigérées pour une période allant de un à quatre jours et 47 étaient des cornées congelées avant mars 1988. EYE BANK OF BRITISH COLUMBIA, *Canadian Eye Bank Statistics April 1st 1988 to March 31st 1989* [non publié].

159. Voir R.G. BUNGE, W.C. KEETTEL et J.K. SHERMAN, « Clinical Use of Frozen Semen: Report of Four Cases » (1954), 5 *Fertil. Steril.* 520.

160. Voir Jacques E. RIOUX et C.D.F. ACKMAN, « Artificial Insemination and Sperm Banks: The Canadian Experience », dans Georges DAVID et Wende S. PRICE (dir.), *Human Artificial Insemination and Semen Preservation*, New York, Plenum Press, 1980, p. 31.

161. SBSC, *Rapport du Comité consultatif sur le stockage et l'utilisation du sperme humain*, Ottawa, SBSC, 1981, pp. x, xi, 78.

162. SBSC, Centre fédéral sur le SIDA, « Lignes de conduite pour la prévention de l'infection à VIH dans la transplantation d'organe et de tissu » (octobre 1989), 15S4 (Suppl.) *Rapport hebdomadaire des maladies au Canada* 19 [ci-après CFSIDA].

163. Voir Derek J. JONES, « Artificial Procreation, Societal Reconceptions: Legal Insight from France » (1988), 36 *Am. J. Comp. L.* 525.

164. Voir CFSIDA, *op. cit.*, note 162, p. 5 (utilisation de sperme frais non recommandée). Voir également SOCIÉTÉ CANADIENNE DE FERTILITÉ ET D'ANDROLOGIE, *Insémination thérapeutique avec sperme de donneur*, Montréal (Qc), la Société, 1988, p. 3.

165. Voir CRD, *La procréation médicalement assistée*, Document de travail n° 65, Ottawa, la Commission, 1992, et AMERICAN MEDICAL ASSOCIATION, « Board of Trustees Report : Frozen Pre-Embryos » (1990), 263:18 *JAMA* 2484. Pour une discussion sur les litiges relatifs aux embryons congelés, voir *infra*, note 415.

Banques d'ADN et de cellules : La prolongation de la période de réfrigération et la congélation à long terme des cellules humaines a facilité la mise au point du stockage des cellules et de l'ADN comme outil de diagnostic. Les cellules humaines congelées demeurent viables pendant vingt ans[166]. Le stockage à long terme facilite la recherche ; il permet, par exemple, de faire des comparaisons entre des cellules que l'on soupçonne de présenter des anomalies génétiques, et des cellules qu'on a stockées en sachant qu'elles présentaient de telles anomalies. Ces travaux sont réalisés, entre autres, grâce au Répertoire des souches de cellules humaines en mutation de l'Hôpital de Montréal pour enfants.

Le stockage de l'ADN joue également un rôle dans le diagnostic des maladies génétiques. Une banque d'ADN est un endroit où l'on conserve l'ADN pour analyse future[167]. L'ADN est extrait des cellules du sang préservé, ainsi que de tissus ou de cellules viables frais ou congelés. Il peut ensuite être stocké indéfiniment dans des micro-éprouvettes pour utilisation future dans le diagnostic. On tente actuellement, dans le cadre d'un programme de dépistage entrepris récemment dans quatorze centres du Canada, de déterminer si des patients sont porteurs du gène de la chorée de Huntington. Or, il peut s'avérer nécessaire à cet effet de prélever un échantillon d'ADN sur un tissu préservé d'un parent décédé, si l'on n'avait pas conservé des échantillons de sang[168]. La Banque canadienne de tissu du cerveau, à Toronto, a parfois été en mesure de fournir les tissus requis dans le cadre de ce programme. Depuis des années, la Banque entrepose des tissus du cerveau, donnés aux fins de recherche[169]. Récemment, elle a fourni aux analystes génétiques des tissus du cerveau de parents décédés, dont on extrait l'ADN en vue de dépister la présence du gène de la chorée de Huntington. La Banque pourrait jouer un rôle semblable dans le cas d'autres maladies dégénératrices du cerveau, comme la maladie d'Alzheimer, si l'on parvenait à identifier les gènes de celles-ci[170].

Banques d'os : Le Canada compte environ soixante banques d'os[171] capables de conserver indéfiniment des os congelés[172]. Les os sont généralement utilisés en chirurgie de reconstruction, notamment dans le traitement des tumeurs ou des fractures[173], et ils

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166. Linda MADISEN et autres, « DNA Banking: The Effects of Storage of Blood and Isolated DNA on the Integrity of DNA » (1987), 27 *Am. J. Med. Genet.* 379, 388.

167. AD HOC COMMITTEE ON DNA TECHNOLOGY, AMERICAN SOCIETY OF HUMAN GENETICS, « DNA BANKING AND DNA ANALYSIS: POINTS TO CONSIDER » (1988), 42:5 *Am. J. Human Genet.* 781 [ci-après ASHG].

168. Voir L. MADISEN et autres, *loc. cit.*, note 166, 380. Voir également Lawrence SURTEES, « Doctors Using New Gene Probes in Huntington's Disease Program », *The [Toronto] Globe and Mail* (29 août 1988) A14 ; Kathleen NOLAN et Sara SWENSON, « New Tools, New Dilemmas: Genetic Frontiers » (1988), 18:5 *Hast. Cent. Rep.* 40. Voir en général, Note, « Legal Implications of the G-8 Huntington's Disease Genetic Marker » (1988-1989), 39 *Case W. Res. L. Rev.* 273.

169. Concernant les usages britanniques, voir Diana BRAHAMS, « Brain Banks » (1990), 335:8684 *Lancet* 282.

170. Voir Harold M. SCHMECK, « Gene-Mappers Identify Dozens of Trouble Spots », *New York Times* (20 juin 1989) C1, C6 (les cartographes des gènes tentent d'identifier les chromosomes ou les gènes reliés à la maladie d'Alzheimer, au syndrome de Down, au nanisme et à l'épilepsie).

171. Comparer Gordon RUSSELL, Richard HU et Jim RASO, « Bone Banking in Canada: A Review » (1989), 32:4 *Can. J. Surg.* 231 et CFSIDA, *op. cit.*, note 162, p. 19.

172. Nikki JACKSON JACOBS, « Establishing A Surgical Bone Bank », dans Kenneth FAWCETT et Alice R. BARR (dir.), *Tissue Banking*, Arlington (VI), American Association of Blood Banks, 1987, p. 67.

173. Voir *ibid.* Voir aussi Allan E. GROSS, « The Use of Allografts in Orthopaedic Surgery » (1989), 6 *Transplantation/Implantation Today* 44.

sont prélevés sur des donneurs vivants ou des cadavres. Les donneurs vivants peuvent faire des dons d'os à l'occasion d'une intervention chirurgicale comme, par exemple, le remplacement complet de la hanche ou du genou[174]. Le prélèvement d'os sur des cadavres, habituellement des os longs de la jambe et du bras, peut se faire à l'occasion d'un prélèvement d'organes, ou de manière distincte[175].

Les fonctions médicales et sociales de ces banques de tissus ont évolué au même rythme que la technologie de conservation[176]. La possibilité de préserver toute une gamme de tissus humains et de substances corporelles soulève diverses questions. Quels sont les critères, médicaux et autres, régissant la participation des donneurs et des receveurs[177] ? Quelles sont les conditions rattachées au consentement éclairé des donneurs et des receveurs, et quelles en sont les conséquences[178] ? Quelles sont les limites du devoir de confidentialité relatif aux dossiers médicaux[179] ? Les procédures de stockage devraient-elles être régies par des normes professionnelles ou par une loi[180] ? Dans quelle mesure une banque devrait-elle être tenue pour responsable si elle fournit des tissus contaminés[181] ?

Si l'établissement de nouvelles méthodes de stockage tend à créer de nouvelles applications médicales, il peut également susciter de nouveaux problèmes. C'est ce qui se passe dans le cas du stockage des tissus autologues. Contrairement aux donneurs traditionnels, qui font un « cadeau anatomique » à la collectivité lorsqu'ils font un don à une banque de tissus, certaines personnes donnent du sang, de la moelle osseuse, de l'ADN ou des substances reproductives en prévision de traitements administrés à elles-mêmes ou à des membres de leur famille — il serait plus exact de les considérer comme des « déposants »[182].

Depuis peu, par exemple, on voit des Canadiens demander à la Croix-Rouge ou à une banque de sang commerciale de conserver une certaine quantité de leur sang[183]. De

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174. N. Jackson Jacobs, *loc. cit.*, note 172.

175. Voir William W. Tomford et Henri J. Mankin, « Cadaver Bone Procurement », dans K. Fawcett et A.R. Barr (dir.), *op. cit.*, note 172, p. 97.

176. Voir en général, T.F. Kirn, « Tissue Banking in Midst of Revolution of Expansion as More Uses Are Found for Various Transplants » (1987), 258:3 *JAMA* 302.

177. Voir Ken Pole, « Red Cross Challenged Over Blood Donor Policy », *The Medical Post* (20 juin 1989) 12 (contestation de la politique de la SCCR concernant les donneurs de sang). Pour une discussion sur les litiges concernant le droit de bénéficier des services des banques de sperme, voir D.J. Jones, *loc. cit.*, note 163.

178. Le consentement donne-t-il des droits sur le contrôle et la transplantation des tissus ? Voir Bartha M. Knoppers et Claude M. Laberge, « DNA Sampling and Informed Consent » (1989), 140:9 *Journal de l'Association médicale canadienne* 1023, 1027. Voir également *infra*, note 184.

179. Voir en général, Lorne Elkin Rozovsky et Fay Adrienne Rozovsky (dir.), *The Canadian Law of Patient Records*, Toronto, Butterworths, 1984. Voir également, *infra*, ch. III.

180. Voir *supra*, note 151.

181. Voir *infra*, notes 501-503.

182. Voir ASHG, *loc. cit.*, note 167, 782.

183. Voir Anne Gilmore « Red Cross Gets Go-Ahead for Autologous Blood Service » (1988), 138:2 *Journal de l'Association médicale canadienne* 157. Voir également Société canadienne de la Croix-Rouge, *op. cit.*, note 37, p. 11 (collecte de sang autologue à dix-sept centres) ; National Blood Resource Education Program Expert Panel, « The Use of Autologous Blood » (1990), 263:3 *JAMA* 414.

telles pratiques tendent à modifier les relations qui existent entre les banques de tissus et les « déposants », particulièrement en ce qui a trait au contrôle ou à la propriété des substances déposées[184]. Enfin, il convient de signaler qu'en plus de servir de dépositaires aux fins de thérapie et de recherche médicale, les banques de tissus jouent un rôle dans certaines entreprises de nature commerciale, par exemple en stockant des lignées cellulaires humaines et des produits biologiques humains brevetés[185].

III. Coordination de l'offre et de la demande

Afin de coordonner l'offre et la demande, on a établi des réseaux locaux et internationaux d'échange de tissus humains. Certaines initiatives sont intégrées dans un système national cohérent. Par exemple, les dix-sept centres de transfusion de la Croix-Rouge canadienne répondent en grande partie aux besoins régionaux en matière de collecte et de distribution de sang — cela, dans le cadre de services nationaux, selon des principes communs et des procédures uniformes[186]. Le système est l'aboutissement de quarante ans d'expérience et d'évolution.

Les registres de donneurs de tissus humains et les réseaux d'échange d'organes sont un phénomène plus récent. Les registres de donneurs rassemblent le nom et la fiche médicale des donneurs possibles d'organes, ce qui permet de vérifier rapidement la compatibilité entre les tissus du patient et ceux du donneur. Afin d'élargir le réseau de donneurs non apparentés dans le cas des greffes de moelle osseuse, par exemple, la Croix-Rouge canadienne a récemment établi un registre national de 100 000 donneurs, pouvant fournir des tissus compatibles aux centres canadiens pratiquant ces interventions[187]. La Croix-Rouge prévoit que le registre permettra de procéder à environ quatre cents greffes de plus par an[188].

Les réseaux d'échange d'organes fonctionnent selon les mêmes principes. Il existe au Canada neuf programmes de récupération d'organes[189]. Le premier réseau est le fruit d'un effort de coopération entre quatre centres de transplantation de Toronto en 1976. Dès 1978, le Programme de récupération et d'échange de multiples organes de l'Ontario (REMO) s'occupait de la récupération d'organes partout dans la province. Une équipe

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184. Voir ASHG, *loc. cit.*, note 167, 782 (l'ADN est la propriété du déposant, sauf stipulation contraire). Voir également *infra*, ch. III.

185. Voir AMERICAN TYPE CULTURE COLLECTION, *Catalogue of Cell Lines and Hybridomas*, 5e éd., Rockville (Md.), American Type Culture Collection, 1985, p. vi.

186. Voir, *supra*, le texte accompagnant les notes 34 à 39.

187. Voir *supra*, notes 50, 51. À titre de comparaison, le registre américain est relié à cinquante banques de sang et dix-sept centres de greffe de moelle osseuse. Jane E. BRODY, « New Registry is Raising Hope for Those in Need of Bone Marrow », *New York Times* (12 janvier 1988) C1.

188. *Ibid.*

189. Anne GILMORE, « Procuring Donor Organs: Firm But Friendly Encouragement Required » (1986), 134:8 *Journal de l'Association médicale canadienne* 932, 937.

chargée de la récupération des organes est à l'œuvre vingt-quatre heures par jour. On donne des conseils aux hôpitaux et on organise le transfert des donneurs vers les centres de transplantation[190]. Des programmes semblables existent en Colombie-Britannique, au Manitoba, en Saskatchewan, en Alberta, dans les Maritimes et au Québec[191].

Les programmes de récupération d'organes et les centres de transplantation jouent un rôle crucial dans le processus du don d'organes. Ce processus commence par le dépistage des donneurs possibles. Le donneur typique est la personne qui a subi des dommages irréversibles au cerveau, souvent lors d'un accident de la circulation. Il n'est donc pas surprenant que la plupart des donneurs proviennent des salles de soins intensifs des grands hôpitaux[192]. Lorsqu'un donneur possible est signalé, on vérifie s'il a indiqué sa volonté quant au prélèvement d'organes ou de tissus (par exemple, sur son permis de conduire). S'il ne l'a pas fait, on peut s'adresser au plus proche parent du patient, qui est légalement autorisé à refuser le prélèvement ou à y consentir[193].

Une fois la mort cérébrale attestée, soit au bout de quelque vingt-quatre heures[194], le plus proche parent signe les formules de consentement requises. Le donneur est ensuite maintenu mécaniquement en vie et il reçoit sans interruption des soins cliniques et biochimiques intensifs, pour la préservation de ses organes en vue de leur transplantation[195]. Les soins peuvent comprendre l'injection d'antibiotiques pour combattre une infection, la vérification de la tension artérielle et de la température du corps, la rotation du corps afin de prévenir la formation d'ulcères de la peau, l'enregistrement à toutes les heures de la quantité d'urine recueillie et même la réanimation, dans les rares cas d'arrêt cardiaque durant la phase de maintien[196]. La vérification de la compatibilité des tissus et des groupes sanguins précède également l'intervention chirurgicale proprement dite. En outre, les tissus et le sang des donneurs doivent faire l'objet d'un dépistage rigoureux des maladies transmissibles[197].

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190. ONT, *op. cit.*, note 29, p. 114.

191. Voir COMITÉ CONSULTATIF FÉDÉRAL-PROVINCIAL DES SERVICES EN ÉTABLISSEMENT ET DES SERVICES MÉDICAUX, SOUS-COMITÉ SUR LES PROGRAMMES INSTITUTIONNELS, *Services hospitaliers de don d'organes et de tissus : Guide pour l'établissement de normes régissant les services spéciaux dans les hôpitaux*, Ottawa, Approvisionnements et Services Canada, 1988, pp. 39-42.

192. ONT, *op. cit.*, note 29, p. 103. Joseph M. DARBY et autres, « Approach to Management of the Heartbeating "Brain Dead" Organ Donor » (1989), 261:15 *JAMA* 2222 (98 %).

193. Voir *infra*, ch. III.

194. Voir CONGRÈS CANADIEN DES SCIENCES NEUROLOGIQUES, « Recommandations au sujet des critères de mort cérébrale » (1987), 136 *Journal de l'Association médicale canadienne* 200A, reproduit dans COMITÉ CONSULTATIF FÉDÉRAL-PROVINCIAL DES SERVICES EN ÉTABLISSEMENT ET DES SERVICES MÉDICAUX, *op. cit.*, note 191. Voir également CANADIAN CONGRESS COMMITTEE ON BRAIN DEATH, « Death and Brain Death: A New Formulation for Canadian Medicine » (1988), 138:5 *Journal de l'Association médicale canadienne* 405.

195. Voir ONT, *op. cit.*, note 29, p. 93.

196. Voir J.M. DARBY et autres, *loc. cit.*, note 192, 2225-2226.

197. Voir CFSIDA, *op. cit.*, note 162, pp. 1-2 (malgré la transmission de l'infection à VIH dans d'autres pays, aucun cas n'a été rapporté au Canada suite à une transplantation des reins, du foie, du cœur, du cœur-poumon, de la cornée, de la peau, d'un os ou de la moelle osseuse ; un seul cas a été rapporté et il s'agissait d'une mère porteuse) ; U.S. CENTERS FOR DISEASE CONTROL, « Semen Banking, Organ and Tissue Transplantation, and HIV Antibody Testing » (1988), 259:9 *JAMA* 1301. Pour de la jurisprudence portant sur le contrôle des tissus transplantés, voir *infra*, note 501.

Lorsque tous les contrôles ont été effectués et que l'on a constaté la compatibilité entre le donneur et un receveur, on détermine les modalités du prélèvement. Dans le cas où la méthode de prélèvement et de transplantation est bien établie (transplantation rénale, par exemple), une équipe médicale de l'hôpital où se trouve le donneur peut simplement prélever l'organe et l'expédier. On peut aussi transporter le donneur à l'hôpital où se trouve le receveur[198]. Il arrive enfin qu'une équipe chargée de prélever les organes se rende en automobile ou en avion à l'hôpital où se trouve le donneur. Dans ce dernier cas, l'organe est enlevé chirurgicalement, mis dans de la glace, et rapidement rapporté à l'hôpital où se trouve le receveur. L'implantation chirurgicale de l'organe peut alors commencer. Trente-deux heures sont nécessaires pour coordonner le prélèvement et la transplantation d'un organe comme le rein ; le prélèvement de plusieurs organes sur un seul donneur demande dix heures additionnelles[199]. Cette coordination doit parfois avoir lieu à l'échelle internationale[200].

IV. Dilemmes découlant de la nouvelle technologie

L'apparent déséquilibre entre la demande et les tissus disponibles accentue les dilemmes auxquels font face les sociétés où l'on a recours à la technologie de pointe dans le domaine des greffes d'organes et de tissus. Ces dilemmes se manifestent dans les débats sur divers problèmes : vente de tissus humains, exigences relatives au consentement, propriété du corps humain, attribution des organes rares.

A. Pénurie, paiement et biocommerce

Dans quelle mesure la société devrait-elle interdire ou réglementer la vente des parties du corps et des tissus humains ? Certains analystes canadiens sont d'avis que la vente réglementée d'organes pourrait constituer une solution à la pénurie[201]. Si l'on optait pour l'interdiction ou la réglementation, comment devrait-on définir la vente ? Les sommes versées dans le contexte du don de tissus constituent-elles toujours un « prix de vente » ? Qu'en est-il des tissus importés de pays où le don de sperme, de produits sanguins, de lait, de moelle osseuse, de placentas et de reins est rémunéré ?

L'utilisation, au Canada, de produits dérivés du plasma fractionné, transformé commercialement et importé fait ressortir quelques-unes des réalités pratiques qui orientent la politique en vigueur en matière de vente d'organes. La récupération du plasma joue

198. Voir A. Grenvik et autres, « Multiple Organ Procurement by Interhospital Transfer of Heartbeating Cadavers » (1984), 16:1 *Tranplant. Proc.* 251.

199. A. Gilmore, *loc. cit.*, note 189, 936.

200. Voir la discussion concernant les transferts internationaux, *infra*, ch. IV.

201. Voir, par exemple, G. Sharpe, « Commerce in Tissue and Organs » (1985), 17:6 (Suppl. 4) *Transplant. Proc.* 33, 38.

un rôle essentiel dans le traitement médical moderne. Le fractionnement du plasma permet d'en dériver le facteur VIII, agent de coagulation utilisé dans le traitement de quelque deux mille huit cents hémophiles au Canada[202]. Malheureusement, les besoins mondiaux de facteur VIII excèdent largement les quantités disponibles[203]. Presque tout le plasma recueilli par la Croix-Rouge canadienne est fractionné en facteur VIII et environ quinze autres produits, dans un laboratoire américain. D'autres sous-produits du plasma associés au facteur VIII sont achetés sur le marché international[204], qui est approvisionné en grande partie par l'industrie américaine de transformation du plasma. Celle-ci dépend tellement du plasma obtenu contre paiement que plus de la moitié de l'approvisionnement mondial en plasma fractionnable est obtenu grâce à la transformation du plasma provenant de donneurs rémunérés[205]. L'obtention du facteur VIII par recombinaison génétique pourrait transformer les marchés nationaux et internationaux de plasma[206].

Toutefois, la pénurie actuelle de plasma fractionné, au Canada et dans le monde, donne à penser que la vente et l'achat de produits biologiques humains peu abondants s'avère parfois nécessaire. Un décalage considérable entre l'offre et la demande tend à revêtir d'une valeur économique les substances biologiques rares. Le fait que cette valeur économique puisse se refléter dans le prix sur le marché libre ou le marché noir donne encore plus d'importance à la question fondamentale de savoir si la société souhaite adopter le principe de la gratuité, ou bien permettre que les tissus humains et les substances corporelles (ou certains d'entre eux) soient l'objet d'échanges commerciaux. Et dans le cas où l'aversion d'ordre éthique subsisterait, comment devrait-elle s'exprimer dans la loi, face à la valeur économique croissante des tissus humains rares et au fait que le versement d'argent pour les obtenir est de plus en plus courant ? Ces problèmes seront étudiées plus à fond dans les chapitres subséquents.

B. Intégrité corporelle et consentement

Les besoins de la médecine moderne et les modalités du prélèvement des tissus humains soulèvent aussi de nombreuses questions ayant trait au consentement, à la possession et à la propriété des tissus humains, ainsi qu'à l'éthique et à la légalité du maintien en vie de personnes cérébralement mortes, en vue du prélèvement de leurs tissus et de leurs organes et à d'autres fins médicales. Bon nombre de ces questions concernent l'intégrité physique et morale des donneurs — vivants ou morts — de même que le bien-être affectif et les convictions religieuses de leurs familles.

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202. Communication avec la Société canadienne de l'hémophilie.

203. Anthony F.H. BRITTEN, « Worldwide Supply of Blood and Blood Products » (1987), 11:1 *World J. Surg.* 82.

204. CCS, *op. cit.*, note 35, p. 72.

205. A.F.H. BRITTEN, *loc. cit.*, note 203, 84.

206. Simon JONES, « Genetically Engineered Synthetic Factor B Gives Hemophiliacs New Hope », *The Medical Post* (15 novembre 1988) 11, et Richard SCHWARTZ et autres, « Human Recombinant DNA — Derived Antihemophilic Factor (Factor VIII) in the Treatment of Hemophilia A » (1990), 232:26 *N. Engl. J. Med.* 1801.

(1) Consentement exprès ou présomption de consentement

Le principe du consentement éclairé signifie, en gros, que les professionnels de la santé peuvent porter atteinte à l'intégrité corporelle d'un patient lorsque ce dernier y a consenti[207]. Ce principe est applicable aux receveurs ainsi qu'aux donneurs vivants. Toutefois, certaines personnes se demandent dans quelle mesure il devrait s'appliquer dans le cas où un donneur potentiel meurt à l'hôpital sans avoir fait connaître sa volonté quant à l'éventuelle utilisation de ses tissus ou de ses organes.

La société devrait-elle exiger le consentement du plus proche parent dans de telles circonstances ? D'aucuns prétendent que cette exigence entrave indûment le processus du prélèvement, diminuant ainsi le nombre d'organes disponibles[208]. Ils proposent plutôt que le consentement à l'utilisation de son corps à des fins médicales soit présumé par la société, sauf indication contraire. L'importance que présente pour la collectivité l'obtention d'organes vitaux justifie-t-elle l'établissement d'une présomption de cette nature ? Cette question doit faire l'objet d'un examen approfondi. D'une part, la création d'une telle présomption s'écarterait de l'usage canadien, mais d'autre part elle existe dans plusieurs pays étrangers.

Toutefois, les considérations relatives à la présomption de consentement débordent le cadre de la pénurie de tissus humains. Certains estiment en effet qu'il y aurait lieu de présumer aussi le consentement du plus proche parent à l'utilisation du corps du patient cérébralement décédé et maintenu en vie par des moyens mécaniques, aux fins de recherche et d'expérimentation médicales, ainsi que de formation des étudiants en médecine[209]. Est-il possible de défendre cette proposition d'un point de vue éthique et juridique ? Vu l'opposition entre les principes du consentement éclairé et de la présomption de consentement, vu aussi les valeurs et les droits en jeu, il est indispensable d'examiner plus à fond la question.

Nous étudierons aussi, dans les chapitres subséquents, certains problèmes relatifs au consentement. Ceux qui ont trait à la transplantation d'organes sur des mineurs ou des incapables ne sont pas nouveaux[210]. Mais la controverse actuelle sur l'utilisation de tissus prélevés sur des nouveau-nés anencéphales soulève des problèmes inédits d'ordre éthique et juridique quant à la définition de la mort.

(2) Droit de propriété

Suivant un principe de droit fort ancien, la notion de propriété est inapplicable à l'égard du corps humain. Quelles sont les conséquences de ce principe dans le contexte de

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207. Voir *infra*, ch. III.

208. Voir, par exemple, Thomas E. STARZL, « Implied Consent for Cadaveric Organ Donation » (1984), 251:12 *JAMA* 1592.

209. Voir *infra*, ch. III.

210. *Ibid.*

l'utilisation, de l'échange et du stockage de plus en plus fréquents, à des fins thérapeutiques et biotechnologiques, de substances corporelles prélevées sur des donneurs vivants ou morts[211] ? De nouveaux conflits juridiques relativement au contrôle et à la propriété des substances corporelles ont récemment surgi à l'étranger[212]. Certains d'entre eux portaient sur des substances déposées dans des banques de tissus humains. D'autres ont opposé des personnes ayant fourni des cellules et des tissus humains et celles qui les avaient prélevés pour les utiliser à des fins biotechnologiques ou thérapeutiques[213]. Les premières ont-elles des droits sur les profits tirés des avantages thérapeutiques de la biotechnologie ? Ces conflits invitent la société à revoir la valeur qu'elle attribue aux tissus humains, ainsi que le régime juridique dont ils font l'objet. En outre, des problèmes suscités par la biotechnologie nous forcent à examiner les avantages et les limites de la notion de propriété, s'agissant du corps humain. Nous examinerons certaines de ces questions.

C. Affectation des ressources médicales

Enfin, nous nous sentons obligés d'attirer l'attention sur certaines questions importantes qui débordent le cadre strict de la présente étude. La tension croissante entre la lutte contre la maladie et le coût de la haute technologie médicale impose des choix pénibles concernant le rationnement ou la répartition de ressources médicales nettement insuffisantes[214]. Le Canada s'est engagé à fournir un accès raisonnable aux services médicaux hospitaliers nécessaires[215] ; cela donne-t-il aux patients le droit d'exiger de profiter de la technologie du remplacement des organes ? La portée de ce droit n'est pas claire. Dans une affaire britannique où l'on tentait de forcer le ministre de la Santé à se conformer à son obligation de fournir des services de santé complets, lord Denning a déclaré :

> [TRADUCTION]
> Comme l'a dit le lord juge Oliver au cours des débats, il n'est pas possible de supposer que le Secrétaire d'État doit fournir tous les appareils de dialyse rénale demandés, ou offrir tous les nouveaux traitements, notamment la transplantation cardiaque, dans chaque cas où une personne pourrait en retirer un avantage[216].

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211. *Ibid.*

212. *Ibid.*

213. *Ibid.*

214. Voir P. MORGAN et L. COHEN, « The Ottawa Heart Institute: It's Good, But Can We Afford It? » (1990), 142:6 *Journal de l'Association médicale canadienne* 616 ; Calvin R. STILLER, « High-Tech Medicine and the Control of Health Care Costs » (1989), 140:8 *Journal de l'Association médicale canadienne* 905. Voir en général, U.S. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH [ci-après PRESIDENT'S COMMISSION], *Securing Access to Health Care*, Washington (D.C.), la Commission, 1983.

215. Voir la discussion au sujet de la *Loi canadienne sur la santé*, *infra*, ch. III, section III.A(4).

216. *R.* c. *Secretary of State for Social Services*, 18 mars 1980, (C.A.), [non publié mais peut être consulté par le truchement de la banque informatique Lexis], analysé dans Diana BRAHAMS, « Enforcing a Duty to Care for Patients in the NHS » (1984), 2:8413 *Lancet* 1224.

En fait, les énormes ressources financières et médicales qu'exigent les transplantations d'organes relevant des techniques les plus avancées ont amené certains analystes[217] à conclure que ces ressources devaient être affectées aux domaines où les besoins sont les plus grands. L'idée a été retenue par certains hommes politiques. L'État de l'Oregon, par exemple, pour s'acquitter de son obligation de fournir les soins médicaux raisonnables et « nécessaires[218] » dans une période où les ressources sont insuffisantes, a choisi de financer uniquement les transplantations rénales et les greffes de la cornée, ce qui permet d'augmenter les sommes attribuées aux soins aux femmes enceintes et aux nouveau-nés[219]. Si la meilleure façon de procéder à ces choix de société consiste à discuter ouvertement des aspects éthiques, à effectuer des analyses économiques et à faire une évaluation rigoureuse de la technologie médicale, il est indispensable d'établir à cet effet des mécanismes sociaux et institutionnels adéquats. Le groupe de travail fédéro-provincial sur les transplantations a conclu que les transplantations rénales (et, dans une moindre mesure, les transplantations cardiaques ainsi que les greffes de la moelle osseuse) étaient rentables, tout en indiquant que, pour les transplantations d'autres organes, l'évaluation de la technologie et les études de rentabilité en sont encore aux premières étapes[220]. Les nouvelles données qu'on obtiendra aideront à répondre à une question de plus en plus incontournable : quel est l'investissement optimal que la société peut faire dans les soins primaires et dans la médecine relevant de la technologie de pointe ?

Les décisions prises à cet égard ont des répercussions évidentes pour les consommateurs des soins de santé. Par ailleurs, s'il est décidé d'appuyer ou de financer les transplantations d'organes, sur quels critères l'attribution des organes rares devrait-elle être fondée ? Par exemple, est-il acceptable, du point de vue de l'éthique, de rayer des listes d'attente pour les transplantations du foie les patients atteints d'une maladie causée par leur alcoolisme[221] ? La question a récemment suscité un débat dans les publications

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217. Comparer « Report of the Massachusetts Task Force on Organ Transplantation » (1985), 13:1 *Law Med. Health Care* 8 et Thomas D. OVERCAST et Roger W. EVANS, « Technology Assessment, Public Policy and Transplantation: Restrained Appraisal of the Massachusetts Task Force Approach » (1985), 13:3 *Law Med. Health Care* 106. Voir également H.T. ENGELHARDT, « Shattuck Lecture — Allocating Scarce Medical Resources and the Availability of Organ Transplantation » (1984), 311:1 *N. Engl. J. Med.* 66.

218. Tout comme c'est le cas au Canada, l'obligation découle de la participation au programme fédéral d'assurance-maladie (*medicare*). Aux É.-U., il y a eu des litiges sur la question de savoir si les lois récentes relatives aux transplantations modifient l'obligation de fournir les soins de santé raisonnables et nécessaires. *Ellis* c. *Patterson*, *infra*, note 1001, 54 (étude des litiges suscités aux É.-U. par la question du financement des transplantations).

219. Voir Jennifer DIXON et H. Gilbert WELCH, « Priority Setting: Lessons from Oregon » (1991), 337:8746 *Lancet* 891.

220. Voir FEDS, *op. cit.*, note 29, p. 53. Voir également R.W. EVANS et autres, *loc. cit.*, note 66 ; Évaluation des greffes du foie, *op. cit.*, note 80 ; R.W. EVANS, « The Economics of Heart Transplantation » (1987), 75:1 *Circulation* 63. Pour une évaluation préliminaire de la technologie de la transplantation de la moelle osseuse, voir *Cost Effectiveness*, *op. cit.*, note 46. Voir en général, INSTITUTE OF MEDICINE, *Assessing Medical Technologies*, Washington (D.C.), National Academy Press, 1985.

221. Comparer Carl COHEN et autres, « Alcoholics and Liver Transplantation » (1991), 265:10 *JAMA* 1299 ; Alvin H. Moss, « Should Alcoholics Compete Equally for Liver Transplantation? » (1991), 265:10 *JAMA* 1295 ; Kevin SCHWARTZMAN, « *In Vino Veritas*?: Alcoholics and Liver Transplantation » (1989), 141:12 *Journal de l'Association médicale canadienne* 1262 ; *Allen* c. *Mansour*, 681 F. Supp. 1232 (E.D. Mich. 1986) (les critères de sélection de l'État pour une transplantation exigent une abstinence déclarée de deux ans, ce qui constitue une exclusion arbitraire et déraisonnable) ; « Alcoholics to Get Low Priority for Liver Transplants, Hospital Rules », *The [Toronto] Globe and Mail* (16 mars 1990) A10 (il est acceptable du point de vue de l'éthique d'accorder une faible priorité aux alcooliques en attente d'une transplantation du foie).

spécialisées. Se pose alors, dans une perspective plus générale, la question de savoir quels éléments devraient régir l'établissement des priorités sur les listes d'attente : la nécessité médicale ? l'ordre chronologique d'inscription ? le hasard ? la position sociale ? le pronostic médical ? la capacité de payer[222] ? Les réponses dépendent clairement d'un grand nombre de considérations relatives à l'attribution[223] des ressources. Il y a sans doute lieu de penser que, vu les principes fondamentaux de justice et d'efficacité, ainsi que l'intérêt marqué du public à l'égard du don de tissus humains, les médecins qui reçoivent ces tissus détiennent ces précieuses ressources en tant que fiduciaires et qu'ils ont l'obligation de les répartir équitablement et efficacement[224]. En fait, comme ces questions touchent à des valeurs fondamentales et à des problèmes pressants ressortissant à la justice distributive, elles devraient bénéficier de l'attention immédiate des gouvernements, des groupes de professionnels et du public.

V. Éléments régissant l'offre et la demande

L'offre et la demande, on l'a vu dans ce chapitre, sont en constante évolution dans le domaine des tissus humains et des substances biologiques rares. L'état de la technologie de la transplantation, l'amélioration des réseaux de prélèvement des tissus humains, les droits et les obligations juridiques et le bien-fondé de certaines pratiques médicales sur le plan moral — tous ces éléments peuvent jouer un rôle à cet égard.

Ce sont les techniques qui semblent constituer le moteur premier de cette évolution. Citons par exemple les répercussions de la cyclosporine sur le taux de succès des transplantations d'organes, et l'obtention de l'hormone de croissance humaine par le recours aux techniques du génie génétique, qui rend désormais inutile le prélèvement de cette hormone sur l'hypophyse de cadavres.

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222. Voir « Proceedings of a Conference on Patient Selection Criteria in Transplantation » (1989), 21:3 *Transplant. Proc.* Voir également John F. KILNER, « Age as a Basis for Allocating Lifesaving Medical Resources: An Ethical Analysis » (1988), 13:3 *J. Health Pol. Pol'y L.* 405 ; Arthur L. CAPLAN, « Equity in the Selection of Recipients for Cardiac Transplants » (1987), 75:1 *Circulation* 10 ; Karen J. MERRIKIN et Thomas D. OVERCAST, « Patient Selection for Heart Transplantation: When is a Discrimating Choice Discrimination » (1985), 10:1 *J. Health Pol. Pol'y L.* 7 ; Maxwell J. MEHLMAN, « Rationing Expensive Lifesaving Medical Treatments », [1985] *Wis. L. Rev.* 239 ; James F. BLUMSTEIN, « Rationing Medical Resources: A Constitutional, Legal, and Policy Analysis » (1981), 59 *Tex. L. Rev.* 1345 ; Thomas HALPER, *The Misfortunes of Others: End-Stage Renal Disease in the United Kingdom*, New York, Cambridge University Press, 1989 ; Henri J. AARON et William B. SCHWARTZ, *The Painful Prescription: Rationing Hospital Care*, Washington (D.C.), Brookings Institution, 1984 ; Jean de KERVASDOUE, John KIMBERLY et Victor RODWIN, *La Santé Rationnée*, Paris, Economica, 1981 ; Guido CALABRESI et Philip BOBBITT, *Tragic Choices*, New York, Norton, 1978 ; Note, « Due Process in the Allocation of Scarce Life-Saving Medical Resources » (1975), 84 *Yale L.J.* 1734 ; Note, « Scarce Medical Resources » (1969), 69 *Colum. L. Rev.* 620.

223. Voir J.B. DOSSETOR, « Ethical Issues in Organ Allocation » (1988), 20:1 *Transplant. Proc.* 1053. Voir en général Deborah MATHIEU (dir.), *Organ Substitution Technology: Ethical, Legal, and Public Policy Issues*, Boulder (Colo.), Westview, 1988.

224. Voir USTF, *op. cit.*, note 29, p. 80 (les dons d'organes, une ressource nationale).

L'offre et la demande dépendent également de facteurs autres que médicaux. Les débats entourant l'affaire « bébé Fae », l'implantation du cœur artificiel et les exigences relatives au consentement démontrent que les transplantations sont effectuées dans un cadre éthique et juridique en pleine évolution. En outre, certains facteurs administratifs peuvent jouer un rôle, comme le démontrent l'existence de dix-sept cliniques de sang de la SCCR, de neuf réseaux régionaux de prélèvement d'organes ainsi que les progrès réalisés dans la mise en place de réseaux internationaux d'échange de tissus humains.

Enfin, l'attitude du public et des professionnels contribue indubitablement à l'écart entre l'offre et la demande, surtout dans le cas des transplantations d'organes. Peu de gens sont rassurés devant la perspective concrète de leur propre mort. Le décalage entre, d'une part, les enquêtes publiques révélant un appui important au principe du don de tissus et, d'autre part, le nombre de cartes de donneurs effectivement remplies, traduit une certaine ambivalence entourant le processus des dons d'organes[225].

Cette ambivalence est due à plusieurs facteurs — on n'a pas pensé aux aspects pratiques du don d'organes ; on est inquiet face à la mort ; on éprouve des craintes et de la méfiance à propos des critères de détermination de la mort[226]. Cela explique que les hôpitaux canadiens se trouvent constamment dans la situation où un patient qui vient de mourir, et qui satisfait aux critères médicaux pour le prélèvement d'organes, n'a pas fait connaître ses intentions à cet égard. Frappés par la tragédie, les membres de la famille du « donneur » n'évoqueront sans doute pas spontanément la possibilité d'un don d'organes. Y aurait-il lieu de prendre des mesures pour favoriser les prélèvements dans ces circonstances ? Une équipe médicale spécialisée ne pourrait-elle pas, délicatement et en donnant le soutien nécessaire, prendre l'initiative de la demande ? Des études démontrent que la plupart des familles acceptent une telle demande comme faisant partie du deuil[227]. Ou bien, devrait-on éviter d'en parler aux membres de la famille et prélever automatiquement les organes, en présumant que ce geste est justifié pour sauver des vies et épargner des souffrances, et que le défunt consentirait à cette intervention humanitaire ?

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225. Voir Jan A. WALKER et autres, « Parental Attitudes Toward Pediatric Organ Donations: A Survey » (1990), 142:12 *Journal de l'Association médicale canadienne* 1383, 1384 (80 % des familles interrogées sont disposées à faire des dons) ; P.K. BASU, K.M. HAZARIWALA et M.L. CHIPMAN, « Public Attitudes Toward Donation of Body Parts, Particularly the Eye » (1989), 24:5 *C. J. Ophthalmol.* 216 (environ la moitié des répondants désirant faire un don avaient signé une carte de donneur) ; M. ROBINETTE, « Organ Donation: Factors Contributing to the Imbalance Between Demand and Supply », dans David R. GRANT et William J. WALL (dir.), *First Canadian Symposium on Multi-Organ Transplantation: April 28 and 29, 1988*, London (Ont.), University of Western Ontario, Scitex, 1989, p. 69 ; Barbara E. NOLAN et Nicholas P. SPANOS, « Psychosocial Variables Associated with Willingness to Donate Organs » (1989), 141:1 *Journal de l'Association médicale canadienne* 27.

226. B.E. NOLAN et N.P. SPANOS, *loc. cit.*, note 225, 27. Lors d'un récent sondage américain, les deux raisons les plus fréquemment données pour ne pas autoriser un don d'organes étaient (1) « Ils pourraient me faire quelque chose avant que je sois réellement mort » ; (2) « Les médecins pourraient hâter ma mort ». Judith AREEN, « A Scarcity of Organs » (1988), 38 *J. Legal Educ.* 555, 562, où il est question du rapport du groupe de travail sur la transplantation d'organes des É.-U.

227. Voir Helen LEVINE BATTEN et Jeffrey M. PROTTAS, « Kind Strangers: The Families of Organ Donors » (1987), 6:2 *Health Aff.* 35. Voir également *infra*, ch. IV.

Même les médecins peuvent avoir une attitude ambivalente lorsque le donneur n'a pas fait connaître ses intentions. Au cours des cinq dernières années, les analystes canadiens ont souvent lié la pénurie nationale d'organes à la réticence du corps médical à pressentir la famille des donneurs potentiels qui n'ont pas fait connaître leurs intentions. En 1985, un groupe de travail fédéro-provincial sur les transplantations a conclu que cette réticence était l'un des principaux obstacles à l'augmentation des dons d'organes[228]. La même année, des groupes de travail de l'Ontario et de l'Alberta arrivaient à des conclusions semblables[229]. Et plus récemment, un chirurgien canadien spécialisé en transplantations a observé : [TRADUCTION] « Même s'il existe des difficultés à chaque étape du processus de dons, la principale provient du système de soins de santé, surtout en raison de la réticence de la communauté médicale à pressentir les familles d'un donneur possible afin d'obtenir leur consentement au prélèvement[230]. »

De toute évidence, l'aspect tragique des prélèvements et des dons d'organes (la mort d'une personne permet à une autre de vivre) suscite au Canada une certaine ambivalence, qui contribue d'une manière importante à la pénurie actuelle d'organes[231]. À peine 10 à 20 % des donneurs virtuels d'organes deviennent effectivement des donneurs[232]. Or, le groupe de travail fédéro-provincial sur les transplantations a conclu que le nombre d'organes théoriquement disponibles est suffisant, pourvu qu'on puisse les prélever[233]. Quels moyens, le cas échéant, la société devrait-elle prendre pour cultiver les attitudes et les pratiques favorables aux dons d'organes — éducation générale du public et formation professionnelle, augmentation des incitatifs, contrainte légère — afin de tenter d'atténuer la pénurie ? Le droit offre-t-il des éléments de solution, face au problème des donneurs n'ayant pas exprimé leur volonté, comme on l'a suggéré à l'étranger ? Pour répondre à ces questions, il convient d'examiner l'infrastructure éthique et juridique dans laquelle s'inscrivent le prélèvement et la transplantation.

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228. FEDS, *op. cit.*, note 29, p. 95.

229. ONT, *op. cit.*, note 29, p. 97 (on a conclu que le défaut de dépister les donneurs possibles et de mettre en marche le processus des dons constitue un obstacle médical au prélèvement) ; *Report of the Alberta Human Tissue Procurement Task Force*, *op. cit.*, note 143, p. 18 (l'obstacle le plus important à l'obtention d'organes et de tissus humains serait l'attitude de la profession médicale. Peu importe la raison, le personnel médical semble réticent à conseiller le don d'organes.). Voir également *Review of Organ and Tissue Donation and Transplantation in Saskatchewan*, Regina (Sask.), Ministry of Health, 1987, pp. 62, 65.

230. M. ROBINETTE, *loc. cit.*, note 225, 69.

231. Voir en général, Jeffrey M. PROTTAS et Helen LEVINE BATTEN, « Health Professionals and Hospital Administrators in Organ Procurement: Attitudes, Reservations and Their Resolutions » (1988), 78:6 *Am. J. Pub. Health* 642. Voir également ONT, *op. cit.*, note 29, p. 97.

232. M. ROBINETTE, *loc. cit.*, note 225, 69 (10 %) ; ONT, *op. cit.*, note 29 (10%), J.M. DARBY et autres, *loc. cit.*, note 192, 2222 (15 à 20 %).

233. FEDS, *op. cit.*, note 29, p. 95.

CHAPITRE DEUX

Prélèvement de tissus humains et bioéthique

Si la médecine élabore les outils qui permettent de reconstituer le corps humain, l'éthique nous aide quant à elle à fixer les limites morales de l'utilisation de ces outils. Les techniques de remplacement des tissus humains nous offrent de nouveaux moyens pour sauver des vies, objectif revêtu depuis très longtemps d'une valeur morale. La société accueille favorablement ces progrès — c'est tout à fait normal. Toutefois, la protection de la vie n'est pas la seule valeur fondamentale de la société. Le cadre dans lequel se déroule le prélèvement de tissus humains — les méthodes employées pour sauver des vies — peut s'avérer important, ne serait-ce que parce que ces techniques, ces appareils et cette technologie forcent à des choix moraux une société où, par ailleurs, bien des choses ont changé : nouvelles pratiques, nouveaux modes de vie, nouvelles façons d'envisager la vie, la mort, le corps humain, l'existence physique et spirituelle. L'être humain a toujours ressenti l'impérieux besoin de vivre en harmonie avec les instruments qu'il invente, et de comprendre leur portée morale[234] ; cet objectif s'impose également dans le cas des nouvelles techniques médicales ultra-perfectionnées. L'éthique s'intéresse à cette quête constante de l'humanité ; elle nous aide à saisir l'incidence de certains outils, de certaines pratiques et de certaines orientations sur des valeurs humaines diverses et parfois contradictoires.

L'examen, du point de vue moral, des politiques envisageables en matière de prélèvement des tissus humains passe par les trois étapes fondamentales de la bioéthique appliquée : (1) déterminer les valeurs sous-jacentes, (2) soupeser les valeurs qui s'opposent ou se heurtent ; (3) choisir la ligne de conduite ou la politique qui s'accorde avec l'importance relative attribuée aux valeurs en présence[235].

La bioéthique, notamment en ce qui a trait aux transplantations, place au premier plan les principes de l'autonomie, de la non-malfaisance et de la bienfaisance[236]. Le principe

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234. Voir Laurence H. TRIBE, « Technology Assessment and the Fourth Discontinuity: The Limits of Instrumental Rationality » (1973), 46 *S. Cal. L. Rev.* 617. ([TRADUCTION] « Il existe enfin, dit-on, une quatrième discontinuité — entre l'homme et ses machines — à laquelle l'homme doit mettre fin s'il veut être capable de vivre en harmonie avec les outils qu'il se donne et, partant, avec lui-même »).

235. Voir Terrence F. ACKERMAN, « What Bioethics Should Be » (1980), 5:3 *J. Med. Phil.* 260, 261.

236. Voir Tom L. BEAUCHAMP et James F. CHILDRESS, *Principles of Biomedical Ethics*, 3e éd., New York, Oxford University Press, 1989. La justice, un autre principe important en bioéthique, vise à assurer la distribution équitable des ressources et des charges sociales. Étant donné que le présent document porte

de l'autonomie permet aux individus de mener leur vie selon leurs intérêts et leurs objectifs propres. Lorsqu'on demande le consentement d'une personne avant de procéder au prélèvement de ses organes en vue de leur transplantation, on respecte l'autonomie de cette personne. Le principe de non-malfaisance interdit quant à lui de causer préjudice à autrui, alors que le principe de bienfaisance nous encourage à rechercher le bien d'autrui. Le fait de consulter les proches parents d'une personne récemment décédée au sujet du prélèvement de ses tissus peut éviter de leur causer un préjudice dans le cas où ils jugeraient cette intervention offensante à l'égard du corps d'une personne aimée. Le don de tissus humains, par ailleurs, relève du principe de bienfaisance puisqu'il aide à sauver la vie des receveurs.

Il s'avère parfois plus difficile de résoudre les conflits de valeurs en matière de prélèvement de tissus humains que de les déceler. Par exemple, quelle importance convient-il d'accorder à la protection de la vie, lorsque le processus de prélèvement des tissus humains va à l'encontre de croyances religieuses fondamentales ? S'ils estiment que la préservation de la vie et de la santé l'emporte sur les autres valeurs, les décideurs pourraient retenir l'option du prélèvement discrétionnaire. En revanche, si l'on juge primordial de respecter les désirs des proches parents du défunt, on conclura sans doute que le prélèvement est subordonné à leur consentement. Les choix sont difficiles parce que les valeurs contradictoires ne peuvent être réduites à des dénominateurs communs, malgré la volonté d'établir un ordre de priorité pour des raisons d'éthique. Cependant, il n'est pas essentiel que l'ordre de priorité établi entre les valeurs soit absolu. Certains analystes estiment qu'il est possible d'élaborer des politiques de compromis, assurant un certain équilibre entre les valeurs importantes, mais incompatibles, qui sont en jeu dans le processus de prélèvement[237].

C'est à l'aide de ce cadre d'analyse — déterminer les valeurs contradictoires en jeu, tenter de les soupeser et établir un ordre de priorité entre elles — que nous explorons les questions suivantes :

— Quel est le fondement moral de la politique actuelle en matière de don d'organes, par rapport aux autres solutions possibles ?

— Les transplantations dépendent dans une large mesure du prélèvement d'organes sur des cadavres. Quelle est l'incidence de certaines considérations d'ordre moral — respect des personnes, protection de l'intégrité corporelle, affirmation de la dignité humaine, etc. — sur le sort réservé à ceux-ci ?

— Quels arguments d'ordre moral militent pour et contre la vente des tissus humains ?

— Quelles conséquences découlent, sur le plan éthique, du fait d'envisager le corps humain comme un « bien » ?

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sur le prélèvement des tissus humains, les problèmes urgents que pose l'attribution des tissus en quantité insuffisante et des maigres ressources médicales ne sont d'une façon générale pas abordés. Comparer James F. CHILDRESS, « Some Moral Connections between Organ Procurement and Organ Distribution » (1987), 3 *J. Contemp. Health L. Pol'y* 85.

237. Voir David A. PETERS, « Protecting Autonomy in Organ Procurement Procedures: Some Overlooked Issues » (1986), 64 *Milbank Mem. Fund Q.* 241, 263 et David A. PETERS, « Required Request: A Practical Proposal for Increasing the Supply of Cadaver Organs for Transplantation » (1985), 84 *Wis. Med. J.* 10, 12.

La partie I porte sur le prélèvement de tissus sur des cadavres et sur le sens du « préjudice » causé au défunt, du point de vue de l'éthique. La partie II traite du prélèvement de tissus sur des adultes vivants, sur des enfants[238] et sur des personnes atteintes de déficience mentale. Dans la partie III, on se penche sur le don en tant qu'obligation morale. La dernière partie explore la relation qui existe entre le corps physique et la notion de personne, sous trois angles : prélèvement de tissus humains, propriété du corps humain et vente de tissus humains. Au moins une conclusion ressort de ce chapitre : la conception qu'on se fait de la relation entre le corps et la personne influence énormément — et détermine dans bien des cas — le jugement moral que l'on porte sur certaines propositions et certaines pratiques en matière de prélèvement de tissus humains.

I. Donneurs décédés

De quelle façon la société devrait-elle se procurer, à des fins thérapeutiques, les tissus des personnes récemment décédées, en vue de sauver des vies humaines ? Convient-il d'instaurer un régime efficace de prélèvement discrétionnaire ? Faut-il plutôt privilégier la notion de don ? Ces deux solutions extrêmes peuvent sembler un peu éloignées de la réalité sociale. Toutefois, leur examen fait vivement ressortir les fondements moraux, les débats philosophiques et les valeurs contradictoires qui sous-tendent les politiques envisageables en matière de prélèvement de tissus humains, qui vont du pur altruisme au prélèvement discrétionnaire.

A. Altruisme — la valeur morale du don

Au Canada, le mot « don » est associé de très près à la transplantation de tissus humains[239]. Il tire son origine du latin « donum »[240]. C'est souvent par la notion

238. L'utilisation d'enfants anencéphales en tant que « donneurs » d'organes est traitée *infra*, ch. III, section II.B.

239. Les termes et les expressions utilisés à l'égard des greffes et des transplantations de tissus humains sont le reflet de préceptes moraux, qui transparaissent dans les titres des articles consacrés à la question. Voir, par exemple, Alfred M. SADLER et Blair L. SADLER, « A Community of Givers, Not Takers » (1984), 14:5 *Hast. Cent. Rep.* 6. Voir aussi David HELWIG, « Organ Procurement: Coercion or Informed Consent? » (1988), 139:1 *Journal de l'Association médicale canadienne* 59 ([TRADUCTION] « Mais, disait le père, j'ai entendu quelqu'un parler de récolte. Je suis un agriculteur. Je sais ce que c'est que la récolte, et je refuse carrément l'idée — on arrache l'épi de la tige, sans se soucier de la tige. Or moi, je m'en soucie : la tige, c'est mon garçon. » D'aucuns estiment que l'idéologie officielle du prélèvement des tissus humains est à la fois trop simple et trop sentimentale : R.C. FOX, « Organ Transplantation: Sociocultural Aspects », dans Warren T. REICH (dir.), *Encyclopedia of Bioethics*, vol. 3, New York, Free Press, 1978, p. 1166, à la page 1168. Pour une discussion d'ordre anthropologique sur les normes relatives à l'échange de cadeaux, voir Marcel MAUSS, *The Gift: Forms and Functions of Exchange in Archaic Societies*, trad. par I. Cunnison, Londres, Cohen & West, 1969.

240. Le *Petit Robert*, Paris, Le Robert, 1990.

d'altruisme (disposition à s'intéresser et à se dévouer à autrui[241]), qu'on explique la motivation de certaines personnes à faire des dons.

On cite trois grandes raisons à l'appui de l'éthique du don, consacrée dans les principes de la politique nationale du sang et dans la législation canadienne sur le don d'organes[242] : le don altruiste de tissus entretient les liens au sein de la collectivité et encourage la générosité ; il s'accorde avec le respect dû aux cadavres ; il permet d'éviter les effets néfastes et les risques d'une politique de prélèvement discrétionnaire. La première raison fait appel au genre de société que beaucoup pourraient préférer :

> [TRADUCTION]
> Une société où l'on donne et reçoit sera une meilleure communauté humaine qu'une société où l'on prend en vue d'un bien futur. L'œuvre civilisatrice de l'humanité consiste dans la recherche et la consolidation d'un consensus global, et non d'un consensus limité à l'avancement de la science médicale et à la possibilité de prélever des organes sur des cadavres dans le but de sauver des vies. La civilisation suppose que les consensus de la collectivité s'incarnent en chacun de nous, et non que nous vivions dans une collectivité où persistent les consentements et les refus, tout comme nous ne faisons qu'un avec notre corps plutôt que de vivre *dans* notre corps. Le consentement positif requis par les textes législatifs, qui répondent à la nécessité du don en encourageant les donneurs authentiques, satisfait aux exigences d'une véritable communauté humaine. Le prélèvement discrétionnaire, par contre, priverait les individus de la possibilité de pratiquer la vertu de générosité[243].

Vu de la sorte, le don de tissus humains devient le cadeau matériel et symbolique de la vie qui unit des étrangers au sein de nos communautés[244].

La deuxième raison de favoriser l'altruisme est axée sur le rôle du corps dans la notion de « personne ». Pour certains, en effet, la personne est indissociable de son corps et, partant, la dignité du corps est indissociable de la dignité de la personne[245]. Cette association dure même dans la mort, parce que le corps est alors considéré comme le symbole de la personne qui vivait :

> [TRADUCTION]
> Le cadavre, reconnaissons-le, n'est plus un être humain. Il est comme un linceul qui masque, plutôt qu'il exprime, l'âme qui autrefois l'animait. Et pourtant, tant que le corps demeure reconnaissable, même dans la mort, il exige un certain respect. Ce n'est plus une présence humaine, mais il nous rappelle cette présence qui lui était absolument indissociable[246].

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241. *Ibid.*

242. Voir *infra*, ch. III, section III.B.

243. Paul RAMSEY, *The Patient as Person: Explorations in Medical Ethics*, New Haven, Yale University Press, 1970, p. 210.

244. Voir Richard M. TITMUSS, *The Gift Relationship: From Human Blood to Social Policy*, Londres, Allen & Unwin, 1970. Voir également Roberta G. SIMMONS, Susan KLEIN MARINE et Richard L. SIMMONS, *Gift of Life: The Effect of Organ Transplantation on Individual, Family and Societal Dynamics*, New Jersey, Transaction, 1987.

245. William F. MAY, « Attitudes Toward the Newly Dead » (1973), 1:1 *Hast. Cent. Stud.* 3. Voir également William F. MAY, « Religious Justifications for Donating Body Parts » (1985), 15:1 *Hast. Cent. Rep.* 38, 39.

246. W.F. MAY (1973), *loc. cit.*, note 245, 3. Voir également W.F. MAY (1985), *loc. cit.*, note 245, 39-40.

En outre, si l'on associe le principe de la dignité humaine à celui de l'autonomie de l'être humain, un régime de prélèvement qui respecte la volonté exprimée de son vivant par l'intéressé quant au don d'organes semblerait davantage conforme à ces principes.

La troisième raison avancée est que le régime fondé sur la notion de don, en plus de promouvoir l'altruisme et de respecter certains principes, comme l'autonomie de l'être humain, est davantage susceptible que d'autres de contenir les attitudes préjudiciables et les pratiques abusives. Par exemple, d'aucuns s'opposent au prélèvement discrétionnaire d'organes, qui risque selon eux d'encourager des attitudes condamnables réduisant défunts et vivants à un assemblage de pièces interchangeables[247]. Cette crainte est elle aussi étroitement liée à la question de savoir comment les régimes de prélèvement influent sur notre façon d'envisager la personne physique et la personne morale. Le fait d'être perçu comme « un cadavre en puissance, une réserve de pièces de rechange », ou encore comme une marchandise médicale, risque de battre en brèche l'individualité et la dignité humaine ; les êtres humains deviennent alors de simples instruments virtuels au service d'une science biomédicale bien intentionnée.

On craint également que le prélèvement discrétionnaire d'organes altère la relation entre le patient, le médecin et l'hôpital. L'hôpital risquerait de devenir un « ogre », son rôle traditionnel (soigner les malades[248]) perdant de l'importance, et la confiance sur laquelle repose l'art de guérir se trouvant érodée. Certaines études canadiennes et américaines font du reste état de la méfiance et des inquiétudes du public à propos du prélèvement prématuré d'organes[249]. Tout comme la crainte de voir les mourants assimilés à des réserves de pièces de rechange ou les réticences fondées sur le respect dû aux dépouilles, cette méfiance semble en quelque sorte porter sur les greffes d'organes en général. Dans plusieurs pays où les règles régissant les prélèvements diffèrent, par exemple, des recherches et des interventions d'une moralité et d'une légalité douteuses ont eu lieu, dans le cadre de la formation médicale, sur des patients maintenus en vie mécaniquement[250]. Si l'on est incapable de démontrer qu'un régime réduit ou augmente sensiblement les risques que de telles choses se produisent, il faudra sans doute conclure que ce risque est inhérent au prélèvement d'organes, peu importe les règles qui le régissent.

La formulation de ces idéaux et de ces craintes indique en quoi consiste une difficulté fondamentale à laquelle se heurtent les tenants de l'altruisme, au moment où les besoins

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247. Voir P. Ramsey, *op. cit.*, note 243, p. 209. ([Traduction] « Chacun devient, en puissance, un cadavre susceptible d'être utilisé »).

248. Voir W.F. May (1973), *loc. cit.*, note 245, 6.

249. Voir James F. Childress, « Ethical Criteria for Procuring and Distributing Organs for Transplantation » (1989), 14:1 *J. Health Pol. Pol'y L.* 87, 91-92. Voir également *supra*, note 226.

250. On trouvera au chapitre III des détails sur des incidents récents, dont certains ont entraîné des accusations criminelles, tant dans des pays où le consentement doit être exprès que dans des pays où il est présumé. Voir également Willard Gaylin, « Harvesting the Dead » (1974), 249 *Harper's* 23, 26 (description de certains biocentres où des cadavres maintenus en survie mécaniquement sont utilisés aux fins d'enseignement, de la recherche et de la transplantation de tissus), et Paul Taylor, « MDs Ponder What to Do with up to 10,000 "Living Dead" », *The [Toronto] Globe and Mail* (23 août 1989) A1.

pressants de la médecine remettent de plus en plus en question les théories à la base de l'altruisme pur. À l'extrême, on se trouve en effet à opposer d'intangibles préoccupations d'ordre moral et émotif aux bienfaits tangibles et relativement quantifiables d'un accroissement de la quantité de tissus pouvant être prélevés.

Par exemple, si le système du don semble parfaitement adéquat dans le cas du sang, bien peu de personnes prennent des mesures concrètes pour autoriser le prélèvement de leurs organes après leur mort[251]. Le don est peut-être moralement préférable au prélèvement discrétionnaire. Mais jusqu'à quel point ? La pénurie constante amène la société à se poser la question. Ne pourrait-on trouver des mécanismes moins coûteux qui, tout en permettant la pratique de la générosité[252] et l'établissement d'un consensus dans la collectivité, raccourciraient les listes d'attente pour les transplantations ? La minorité de personnes qui font preuve de générosité en donnant leurs organes contribue-t-elle suffisamment au bien-être moral et physique général de la communauté pour qu'il n'y ait pas lieu de modifier le régime actuel ?

Il n'est pas facile de mesurer les bienfaits moraux de l'altruisme qui, tel qu'il est envisagé ici, n'est pas nécessairement synonyme d'actes de libre volonté — sont plutôt visés des actes auxquels on est encouragé. Ceux qui ne sont pas disposés à envisager la mort et à autoriser le prélèvement de leurs organes[253] sont incités à le faire, par des lois et des pratiques sociales. D'aucuns sont d'avis que les bienfaits intangibles découlant, sur le plan de l'édification morale, de cette occasion de faire preuve d'altruisme sont plus importants pour la société que les bienfaits des transplantations[254]. Mais quels sont, plus spécifiquement, ces avantages intangibles qui doivent être mis dans la balance avec les avantages concrets d'une augmentation de la quantité de tissus pouvant être prélevés aux fins de transplantation ? Ceux qui invoquent d'une manière générale le principe de l'altruisme ne le précisent pas ; ils n'expliquent pas non plus pourquoi ces avantages intangibles devraient l'emporter sur la possibilité de prolonger des vies.

Bref, si l'idéal d'une générosité non caractérisée demeure difficile à définir, ne pourrions-nous pas trouver d'autres façons de répondre aux besoins humains immédiats ? Quelles sont les autres solutions moralement acceptables, en ce qui concerne le prélèvement d'organes sur les cadavres, s'il est impossible de préciser ou d'atteindre l'idéal d'une « communauté authentique », ou si le prix rattaché à cet idéal est trop élevé en termes de vies humaines et de souffrances ?

B. Prélèvement discrétionnaire — l'école rationnelle

La tension qui existe entre les besoins immédiats et quantifiables de la médecine, et les bienfaits plus intangibles et sans doute plus symboliques de l'altruisme, pousse certains

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251. Voir, *supra*, le texte accompagnant la note 226.

252. Voir James L. MUYSKENS, « An Alternative Policy for Obtaining Cadaver Organs for Transplantation » (1978), 8 *Phil. Pub. Aff.* 88, 96.

253. Voir P. RAMSEY, *op. cit.*, note 243, p. 210.

254. Voir *id.*, pp. 210-211.

spécialistes de l'éthique à proposer le prélèvement discrétionnaire de tissus sur les cadavres. Pour ceux-ci, le choix se situe entre [TRADUCTION] « l'intérêt ou la vie, d'une part, et, d'autre part, le symbolisme et les sentiments[255]. » Lorsqu'on exprime ainsi les valeurs en opposition, le symbolisme sort perdant :

> [TRADUCTION]
> D'un côté de la balance, il y a la possibilité de sauver des vies ; de l'autre, le droit d'une personne, [. . .] par un rituel symbolique, de transformer son consentement en un « don » authentique. Même dans cette confrontation extrême de l'intérêt et du symbole, [. . .] [les partisans du don d'organes accordent] plus de poids au symbole. Si l'enjeu n'était pas aussi grave, je serais tenté de [les] taxer de sensiblerie.
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> [. . .] [D']après les critères fondés sur l'importance relative [. . .], l'argument de l'intérêt est revêtu d'une plus grande force et d'un plus grand poids que des sentiments heurtés, et devrait l'emporter lorsque les deux sont inconciliables[256].

Cette thèse consiste à dire que le sentiment primaire suscité par un cadavre humain, par exemple, favorise une complaisance émotive dont l'effet est de détourner l'attention des véritables délibérations éthiques ou de masquer les intérêts prédominants. Comme le disait un chercheur, [TRADUCTION] « [l']erreur consiste à accorder une valeur à un symbole, et à se laisser envahir par les sentiments évoqués par celui-ci, au détriment des véritables intérêts, et notamment des intérêts mêmes que représente le symbole[257] ». Les tenants de ce point de vue admettent que « l'utilité sociale » peut être servie par le respect généralisé de certains symboles naturels, mais concluent que cette valeur véritable mais diffuse passerait au second plan lorsque de véritables intérêts sont en jeu[258]. Et si les sentiments sont rattachés à des valeurs véritables, ces valeurs, sans doute en raison de leur caractère « diffus », ne peuvent pas non plus l'emporter lorsqu'elles sont mises en balance avec des intérêts.

À bien des égards, donc, le débat sur le prélèvement d'organes est le reflet d'un débat plus fondamental. Il y a d'une part l'école philosophique dominante, qui considère la morale comme une entreprise rationnelle où la place de l'irrationnel est on ne peut plus ténue, les émotions prenant un sens défini grâce aux images et aux symboles. Cette école rationnelle estime que l'établissement d'un lien entre les émotions, les valeurs et le symbolisme est à tout le moins gênant sur le plan moral, et risque même, dans la pire des hypothèses, d'avoir un effet destructeur sur d'autres valeurs et des intérêts considérés comme supérieurs. D'autre part, il y a l'école selon laquelle la morale vécue est ancrée dans les coutumes, les traditions et les croyances des sociétés et s'exprime autant par les symboles et les sentiments que par la raison[259]. Pour ses tenants, le plus grand danger moral, dans notre

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255. Joel FEINBERG, « The Mistreatment of Dead Bodies » (1985), 15:1 *Hast. Cent. Rep.* 31, 32.

256. *Id.*, 32.

257. *Ibid.* Si l'« erreur » consiste à séparer les intérêts des sentiments que les symboles évoquent, même les sentiments purs peuvent posséder des valeurs légitimes, comme le démontrent les intérêts qu'ils peuvent ultimement traduire. L'« erreur » pourrait être corrigée en précisant l'intérêt associé au sentiment et en l'opposant au « véritable intérêt ».

258. *Ibid.*

259. W.F. MAY (1985), *loc. cit.*, note 245, 38 ([TRADUCTION] « Les théoriciens de l'éthique qui s'intéressent à la question des transplantations d'organes ne font habituellement appel qu'à la raison, sans s'intéresser aux traditions religieuses ni aux collectivités qui, tant bien que mal, incarnent ces traditions »).

société technologique, est que les sentiments soient dévalorisés et que les émotions ne reçoivent ni l'attention ni l'encouragement nécessaires[260]. Les enjeux du prélèvement de tissus humains constituent donc un terrain propice à un débat philosophique fondamental axé sur la morale pratique.

Après avoir cerné les thèses philosophiques en présence, que peut-on dire du rôle des émotions dans la morale ? Il semble évident que la valeur des choix moraux ne dépend pas seulement ni toujours des émotions et du symbolisme. La réflexion rationnelle en est certainement un élément indispensable. Toutefois, deux raisons peuvent amener à douter qu'elle en soit le seul élément légitime. Premièrement, ceux qui refusent catégoriquement de reconnaître un rôle aux sentiments n'ont aucun argument cohérent ni convaincant à invoquer. Leur critique la plus sérieuse est fondée sur quelques-unes des conséquences les plus quantifiables du prélèvement discrétionnaire. Elle utilise des exemples qui comportent leur propre attrait symbolique. C'est ainsi qu'on opposera la non-utilisation du corps d'une personne récemment décédée aux avantages médicaux incalculables présumés découler des autopsies et de la recherche sur les cadavres[261]. Qu'est-ce qu'un patient qui vient de mourir : le symbole d'un être humain, ou bien un potentiel illimité pour la recherche médicale ? Ou les deux, peut-être ?

Deuxièmement, faute d'une théorie plus affirmative et plus cohérente, le point de vue strictement rationaliste tend à revêtir un caractère absolu : on en vient à ne tenir aucun compte des préoccupations morales susceptibles de découler de la réflexion rationnelle-irrationnelle suscitée par l'expérience humaine dans diverses sociétés. On considérera comme dénué de tout caractère moral l'argument suivant lequel le prélèvement discrétionnaire est une pratique répugnante, dans la mesure où cet argument n'est pas fondé sur un intérêt donné ; et il ne pourra l'emporter sur les bienfaits présumés de la pratique en question[262]. Or, une conception moins rigide du rôle des émotions dans les décisions d'ordre moral pourrait entraîner la prise en compte de choix éthiques ne relevant pas de la stricte morale rationaliste.

Si, par conséquent, on peut reprocher aux auteurs qui s'intéressent aux symboles et aux sentiments d'accorder trop d'importance à la force morale des émotions et d'avoir du mal à apprécier les bienfaits moraux de l'altruisme pur, ils semblent tout de même davantage en mesure de prendre en considération les diverses valeurs et solutions morales. La préférence pour l'altruisme n'est pas absolue et, pour les tenants de ce point de vue, ni le don d'organes ni le prélèvement discrétionnaire ne sont mauvais en soi[263] ; mais il convient selon eux d'essayer tout d'abord le don : [TRADUCTION] « l'attitude humaine à l'égard de la mort (et des personnes qui viennent de mourir) est telle que l'on doit tout

260. Sydney CALLAHAN, « The Role of Emotion in Ethical Decisionmaking » (1988), 18:3 *Hast. Cent. Rep.* 9, 12.

261. J. FEINBERG, *loc. cit.*, note 255, 32. On peut se demander si l'appel fondé sur la possibilité de prévenir des « milliers » de maladies inconnues et de décès serait aussi séduisant s'il nous était possible de lire les protocoles et de déterminer la véritable probabilité des avantages découlant de cette recherche particulière sur les cadavres.

262. Voir *id.*, 33.

263. P. RAMSEY, *op. cit.*, note 243, p. 209.

d'abord mettre sérieusement à l'essai un système de dons avant d'envisager le prélèvement discrétionnaire[264] ». En somme, ces auteurs reconnaissent que plusieurs valeurs sont en jeu, et préfèrent une solution qui tente de les concilier. Leur conclusion est en fait relative : [TRADUCTION] « il vaut mieux encourager le don d'organes suivant un système bien établi que de laisser tout latitude aux hôpitaux pour l'utilisation d'organes prélevés sur des cadavres[265]. »

L'opposition entre ces deux écoles de pensée suggère peut-être une voie pour sortir de l'impasse philosophique sous-jacente. Le débat tient à ce que l'on ne s'entend pas sur les valeurs légitimes dont il convient de tenir compte et sur le poids à accorder aux autres valeurs. Mais ce désaccord, quant à lui, a une origine plus profonde, à savoir, des conceptions divergentes concernant la nature de la morale et la relation entre les personnes et leur corps. Pourtant, les deux écoles accordent beaucoup d'importance à la protection de la vie et de la santé — la mésentente porte sur l'importance à attribuer à cet objectif. Mais vu la teneur des thèses en présence, il serait sans doute possible de surmonter l'impasse philosophique en déterminant si la solution du don a été sérieusement mise à l'épreuve. Dans l'affirmative, ses partisans sembleraient disposés à envisager l'établissement d'un régime de prélèvement discrétionnaire. Dans le cas contraire, il faudra selon eux, à cause des valeurs légitimes en opposition, tenter de réformer le régime des dons d'organes, afin de le rendre plus efficace.

C. Le préjudice causé au cadavre

Les cadavres peuvent-ils subir des préjudices ? Cette question, rarement traitée de front, n'en est pas moins toujours présente en filigrane dans le débat. Certains, pour tenter de dissiper les inquiétudes morales des spécialistes des transplantations, prétendent qu'il est impossible de causer un préjudice personnel à un patient décédé[266]. Les personnes décédées subissent-elles un préjudice lorsque les étudiants en médecine pratiquent des interventions sur leurs corps, ou lorsque celui-ci est utilisé pour des recherches non autorisées[267] ? Et si préjudice il y a, quelle en est la nature : une atteinte à l'autonomie, à la dignité humaine ? un préjudice moral subi par la collectivité ?

Il semble peu vraisemblable en tout cas que l'éventuel préjudice causé au cadavre consiste dans une atteinte à l'autonomie. L'autonomie morale permet aux personnes de vivre selon leurs propres valeurs et de se protéger contre ce qui leur semble être une cause de préjudice ou d'exploitation. Or, il va sans dire que les cadavres ne prennent pas de

264. W.F. MAY (1973), *loc. cit.*, note 245, 4.

265. P. RAMSEY, *op. cit.*, note 243, p. 209.

266. Voir Stuart J. YOUNGNER et autres, « Psychosocial and Ethical Implications of Organ Retrieval » (1985), 313:5 *N. Engl. J. Med.* 321, 323.

267. Voir *infra*, ch. III, section II.C(3) et *Arnaud* c. *Odom*, *infra*, note 872.

décisions quant à leur « vie »... À proprement parler, les attributs de l'autonomie n'ont plus de pertinence, parce que la personne décédée n'a pas d'autonomie morale[268].

Est-il possible de causer un préjudice au cadavre en portant atteinte à ses intérêts ? La même logique semble s'appliquer. Suivant la conception rationaliste prédominante, les droits sont attribués uniquement aux personnes qui ont des intérêts. Les intérêts [TRADUCTION] « sont constitués en quelque sorte des besoins et des buts, qui supposent l'existence de quelque chose comme des attentes, des croyances, une conscience cognitive[269]. » Le cadavre, dépourvu de ces attributs, n'aurait donc pas d'intérêts ; et, comme les droits sont fondés sur les intérêts, il n'existerait non plus aucun droit susceptible d'être violé.

Mais tous ne souscrivent pas à cette conception :

> [TRADUCTION]
> [L]es personnes décédées peuvent avoir des droits, soit le droit au respect des promesses que nous leur avons faites de leur vivant et le droit de ne pas être calomniées auprès de ceux qui les connaissaient et les aimaient. Cette conclusion évidemment paradoxale s'appuie sur cette idée : on peut estimer que certains intérêts de la personne décédée continuent d'exister après sa mort, et constituent pour nous des obligations. Nous devons alors conclure que ces intérêts ne peuvent s'éteindre que par la réalisation de ce qui est souhaité, et non simplement par la « satisfaction d'un désir », au sens du contentement de l'intéressé lorsqu'il croit que ses attentes ont été comblées[270].

Selon cette analyse, certains intérêts continuent d'exister après la mort d'une personne et génèrent des droits. Ils se résument habituellement aux intérêts ayant trait à sa réputation, à la disposition convenable de ses biens matériels et au traitement respectueux de sa dépouille[271].

Cette thèse, séduisante à première vue, comporte toutefois certaines limites. Elle est dépourvue de tout fondement théorique quant aux intérêts qu'auraient les personnes décédées. Elle n'offre non plus aucune explication sur la façon dont certains intérêts subsistent après la mort. On évoque simplement une distinction entre la réalisation et la satisfaction des désirs. Comme les intérêts découlent d'états d'esprit subjectifs — les désirs, par exemple — il n'est pas illogique de parler de désirs ou d'intérêts qui seraient réalisés après la mort. Le fait de savoir que nos souhaits seront respectés de façon posthume

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268. Albert R. JONSEN, « Transplantation of Fetal Tissue: An Ethicist's Viewpoint » (1988), 36:3 *Clinical Research* 215, 219; Russell SCOTT, *The Body as Property*, New York, Viking Press, 1981, p. 260 ([TRADUCTION] « Bien entendu, le mort doit être respecté, [...] mais le cadavre est une chose totalement différente du corps vivant. L'idée même d'attribuer la notion d'autonomie personnelle à un cadavre est absurde; au mieux, l'autonomie personnelle n'est étendue qu'artificiellement au-delà de la mort »). Voir cependant COMMISSION DE RÉFORME DU DROIT DE L'AUSTRALIE, *infra*, note 1010.

269. Joel FEINBERG, « Is There a Right to Be Born? », dans James RACHELS (dir.), *Understanding Moral Philosophy*, Encino (Calif.), Dickenson, 1976, p. 346, à la page 349.

270. *Ibid.*

271. Raymond A. BELLIOTTI, « Do Dead Human Beings Have Rights? » (1979), 60 *Personalist* 201, 208. Pour une liste des droits possibles de la personne décédée, voir *id.*, 209.

peut sans doute nous donner un plus grand sentiment d'autonomie personnelle. Il semble aussi permettre d'envisager la mort et de s'y préparer avec plus de sérénité. Certains exemples — mépris total des dernières volontés d'une personne[272] à propos de l'inhumation ou de l'utilisation de son cadavre après la mort — tendent à confirmer que nous avons certains intérêts qui subsistent après notre mort, et qu'une atteinte à ces intérêts constitue une forme de préjudice[273]. Il demeure toutefois impossible de donner de cette intuition une explication philosophique cohérente.

Qu'en est-il des notions plus larges de préjudice, qui englobent le tort moral causé par des actes indécents à l'égard d'un cadavre ou les actes violant la dignité humaine ? La morale, après tout, ne se limite pas à l'obligation de ne pas causer de préjudice. On a pu faire valoir, par exemple, qu'il serait injuste de refuser de décerner une récompense ou de conférer un honneur simplement à cause du décès de l'intéressé. Selon cette opinion, on peut avoir droit à une récompense même si l'on n'est pas personnellement en mesure de la recevoir, pourvu qu'on satisfasse aux conditions requises[274]. De la même manière, l'omission de respecter les dernières volontés d'une personne pour la disposition de ses biens peut causer un tort moral, parce que cela est injuste, même s'il n'est pas possible de parler d'un préjudice causé au défunt. Les contraintes générales de la morale, notamment les impératifs de la justice, pourraient donc interdire certains actes à l'égard des morts[275].

La notion de tort moral suppose que les cadavres méritent une protection morale en vertu de leur fonction symbolique. Cette idée revêt une importance particulière dans les religions qui exigent le respect du cadavre en raison de la croyance selon laquelle les humains, vivants et morts, ont été créés à l'image de Dieu ; les juifs et les chrétiens, par exemple, respectent le corps du mort parce qu'il est le symbole de la personne humaine et de sa dignité[276]. Dans cette perspective, les actes irrévérencieux à l'égard d'un cadavre pourraient aller à l'encontre de croyances religieuses et causer un tort moral symbolique dans la communauté partageant ces croyances, parce qu'ils portent atteinte à la dignité humaine dont semble revêtu le corps humain même après la mort. La question de savoir si cet éventuel tort moral constitue un préjudice semble définitionnelle[277].

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272. Voir D.A. PETERS (1986), *loc. cit.*, note 237, 254.

273. Voir George PITCHER, « The Misfortunes of the Dead » (1984), 21:2 *Am. Phil. Q.* 183 ([TRADUCTION] « Si nous pensons à certains exemples en laissant libre cours à notre intuition, il apparaîtra très clairement que nous croyons que les morts peuvent subir des préjudices »).

274. R.A. BELLIOTTI, *loc. cit.*, note 271, 206.

275. Voir J.F. CHILDRESS, *loc. cit.*, note 249, 98 (Il est possible de causer un préjudice à des personnes si l'on ne respecte pas leur testament). Pourtant, l'idée de préjudice suppose l'existence d'une personne qui en est victime, ce qui pose un problème quand l'intéressé est déjà mort.

276. G.B. WHITE, *op. cit.*, note 91, pp. 138-139.

277. Joel FEINBERG, « Sentiment and Sentimentality in Practical Ethics » (1982), 56 *Proc. Addresses Am. Phil. A.* 19, 20 ([TRADUCTION] « l'indignation peut atteindre une intensité maximale même si aucun préjudice n'est causé, par exemple devant un manque de respect envers certains symboles sacrés, comme un drapeau ou un crucifix »).

Bien entendu, ces concepts de tort ou de préjudice seront contestés, voire redéfinis, par ceux qui défendent d'autres opinions, d'autres valeurs. Nous avons vu que le rôle éthique et la force émotive des symboles en matière de morale sont l'objet de discussions d'ordre philosophique. Les tenants de la morale rationaliste mettent en garde contre le respect exagéré des symboles[278]. L'avertissement s'étend au statut moral des patients qui viennent de mourir :

> [TRADUCTION]
> Un cadavre n'est plus une personne. Même s'il convient de respecter les cadavres parce qu'ils ont déjà été des personnes vivantes, l'obligation de respect a moins de force que lorsqu'elle s'applique aux personnes vivantes. Dans le cas de l'intubation de patients qui viennent de mourir, cette obligation se limite à éviter de défigurer ou de ridiculiser le cadavre[279].

La valeur médicale élevée — peut-être même en hausse — attribuée à l'utilisation du corps humain signifie que les valeurs émotives, religieuses ou symboliques associées à la protection des cadavres doivent être mises dans la balance avec les intérêts médicaux des vivants[280]. Or, ces intérêts médicaux ayant tendance à être plus tangibles, plus quantifiables et plus immédiats, il n'est pas interdit de penser qu'ils l'emporteront sur des valeurs plus émotives, plus éthérées et plus symboliques. Dans de tels cas, il faut procéder à une évaluation comparative des intérêts et des valeurs spécifiques en opposition. Cette comparaison ne se prête pas facilement à une analyse philosophique, mais elle n'en constitue pas moins la clé de la controverse morale relative au prélèvement de tissus humains sur les cadavres.

II. Donneurs vivants

Dans le cas du prélèvement d'organes sur des personnes vivantes, quelles sont les restrictions qu'impose la morale ? Pour les adultes juridiquement capables, le principe du respect de l'autonomie de l'être humain semblerait exclure le prélèvement sans le consentement de l'intéressé. Mais pour les personnes dépourvues de la capacité juridique et de l'autonomie, la situation est moins claire. Est-ce que le fait de traiter les enfants et les personnes atteintes de déficience mentale d'une façon différente des adultes dotés de la capacité constitue une exploitation de leur incapacité et de leur vulnérabilité ? Ou bien, au contraire, cela est-il moralement justifié ?

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278. J. FEINBERG, *loc. cit.*, note 255, 31.

279. James P. ORLOWSKI, George A. KANOTI et Maxwell J. MEHLMAN, « The Ethics of Using Newly Dead Patients for Teaching and Practising Intubation Techniques » (1988), 319:7 *N. Engl. J. Med.* 439, 440 (plaidoyer pour l'utilisation médicale du patient qui vient de mourir, sans le consentement des membres de la famille).

280. R.A. BELLIOTTI, *loc. cit.*, note 271, 207-208.

A. Adultes

Selon la bioéthique moderne, le rôle du consentement dans le traitement médical est notamment de favoriser l'autonomie du patient et de protéger son intégrité corporelle[281]. Toutefois, le consentement ne suffit pas à rendre moralement acceptable une intervention médicale. Suivant des principes biomédicaux généralement reconnus, il faut en plus que le donneur tire profit du sacrifice par la prévention d'un préjudice prévisible ou l'obtention d'un avantage[282]. Dans certains cas, même le consentement et l'indiscutable prévention d'un préjudice peuvent s'avérer insuffisants, parce qu'un père pourrait alors faire don de son cœur à son fils pour sauver la vie de celui-ci :

> [TRADUCTION]
> [L]e don de son propre cœur pourrait bien satisfaire au critère du consentement, si cette condition est nécessaire et suffisante pour rendre le don acceptable. [...] À la rigueur, ce don pourrait également satisfaire au critère de la « prévention du préjudice » — on pourrait juger que la mort d'un fils est une pire épreuve que sa propre mort — ou encore au critère des « avantages spirituels »[283].

Or, un tel don est moralement inacceptable, car il constitue une violation de l'intégrité physique, et aboutit à la mort du donneur[284].

La protection des valeurs associées à l'intégrité physique du donneur suppose, partant, une troisième condition : l'évaluation du rapport risques-avantages[285]. La transplantation de tissus humains est moralement justifiée, selon un auteur, dans l'un ou l'autre des cas suivants : *a*) le risque pour le donneur est considérablement moindre que l'avantage espéré pour le receveur ; *b*) l'avantage objectif pour le receveur est considérablement plus grand que la perte subie par le donneur[286]. La nature des risques physiques pour le donneur dépend largement des tissus prélevés et du stade où est arrivée la technique envisagée. Le risque, la gravité de l'atteinte à l'intégrité corporelle et l'irréversibilité ne sont pas les mêmes selon qu'on donne du sang, du sperme, de la moelle osseuse[287] ou un rein. On a estimé, il y a vingt-cinq ans, que les risques associés au don d'un rein étaient comparables à la probabilité d'être blessé ou de perdre la vie dans un accident, pour une

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281. Voir T.L. BEAUCHAMP et J.F. CHILDRESS, *op. cit.*, note 236, p. 76, analysant A.M. CAPRON, « Informed Consent in Catastrophic Disease and Treatment » (1974), 123 *U. Pa. L. Rev.* 364. Voir également Jay KATZ et Alexander Morgan CAPRON, *Catastrophic Diseases: Who Decides What?*, New York, Russell Sage Foundation, 1975, ch. VI, p. 79.

282. Voir, au sujet de la non-malfaisance, T.L. BEAUCHAMP et J.F. CHILDRESS, *op. cit.*, note 236, p. 120.

283. P. RAMSEY, *op. cit.*, note 243, p. 190.

284. Voir *ibid.* Voir également T.L. BEAUCHAMP et J.F. CHILDRESS, *op. cit.*, note 236, p. 370.

285. Voir, au sujet de la bienfaisance, T.L. BEAUCHAMP et J.F. CHILDRESS, *op. cit.*, note 236, p. 194. Voir également P. RAMSEY, *op. cit.*, note 243, p. 195 ([TRADUCTION] « la norme de l'intégrité physique doit être prise en compte dans l'évaluation de la moralité du don de ses propres organes, même si elle ne doit pas nécessairement l'emporter »).

286. P. RAMSEY, *op. cit.*, note 243, p. 195.

287. Voir *Reassessment of Autologous Bone Marrow Transplantation*, *infra*, note 534, p. 2.

personne qui tous les jours doit faire 25 km en voiture pour aller travailler et revenir chez elle[288], en concluant que le sacrifice peut dès lors être tenu pour raisonnable[289].

L'utilisation d'organes prélevés sur des donneurs vivants serait donc assujettie à trois conditions : (1) le donneur doit consentir au prélèvement librement et en connaissance de cause ; (2) il doit y avoir pour lui une probabilité raisonnable d'en tirer avantage ; (3) les avantages escomptés pour le receveur doivent être considérablement plus grands que le préjudice vraisemblable pour le donneur. Cela dit, est-il possible d'en écarter l'une ou l'autre dans le cas, par exemple, des enfants et des personnes atteintes de déficience mentale ?

B. Enfants et personnes atteintes de déficience mentale[290]

Certains tribunaux ont approuvé le prélèvement de tissus humains sur des enfants et des adultes incapables, sans exiger que les conditions énoncées ci-dessus soient toutes les trois remplies[291]. Pourquoi cette différence ? Que devrait-on faire de ces exigences d'ordre éthique lorsque le donneur potentiel est incapable de consentir en raison de son âge ou d'une déficience mentale ? Si l'incapacité et la vulnérabilité n'ont pas pour effet d'interdire tout prélèvement sur ces personnes, quel pourrait être le fondement moral de telles interventions ?

Trois motifs peuvent être invoqués pour justifier l'interdiction d'utiliser comme donneurs d'organes les enfants et les personnes atteintes de déficience mentale[292]. Premièrement, on peut poser que toute atteinte à l'intégrité corporelle est subordonnée au consentement de l'intéressé. Lorsqu'une personne n'a pas la capacité de consentir, l'obtention d'un consentement valide s'avérerait alors impossible, de sorte qu'aucune atteinte à l'intégrité corporelle ne pourrait être justifiée. Deuxièmement, on peut préconiser une interdiction générale en soutenant comme l'ont fait certains que, lorsqu'on veut prélever des organes sur des enfants ou des personnes atteintes de déficience mentale, c'est souvent que, [TRADUCTION] « dans la famille ou à l'extérieur de celle-ci, on a mis dans la balance (consciemment ou non) la valeur sociale attribuée aux personnes concernées[293]. » Troisièmement, on peut faire valoir que la condition relative à l'avantage pour le donneur n'est pas remplie dans un tel cas, les donneurs vulnérables ne recevant aucun avantage physique ou psychologique en contrepartie du prélèvement.

Ces préoccupations d'ordre éthique sont semblables à celles que suscite l'utilisation des enfants et des personnes atteintes de déficience mentale pour des recherches médicales

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288. P. RAMSEY, *op. cit.*, note 243, p. 177, citant J.P. MERRILL, « Letters and Comments » (1964), 61 *Ann. Internal Med.* 356.

289. *Id.*, 196. L'amélioration des techniques chirurgicales et l'expérience accumulée au cours des 25 dernières années donnent à penser que les risques courus par les donneurs sont encore moindres aujourd'hui.

290. Sur l'utilisation d'enfants anencéphales pour le prélèvement d'organes, voir *infra*, ch. III, section II.B.

291. Voir *infra*, notes 300, 302. Voir également R. SCOTT, *op. cit.*, note 268, ch. V, p. 101.

292. R. SCOTT, *op. cit.*, note 268, p. 122.

293. *Ibid.*

dont ils ne reçoivent aucun avantage perceptible[294]. Or, en exigeant le consentement de personnes qui ne sont pas capables de le donner, on se trouverait à empêcher toute recherche médicale non thérapeutique, même si des garanties sont établies quant à leur protection[295]. Cela pourrait aussi s'avérer lourd de conséquences pour d'autres personnes vulnérables souffrant de maladies qui ne sauraient être vaincues sans de nouvelles recherches. Dans le cas des dons d'organes, même si les conséquences possibles d'une interdiction semblable toucheraient sans doute moins de monde, elles pourraient être tout aussi graves sur le plan individuel.

Par ailleurs, il n'est peut-être non plus en soi indiqué d'exiger le consentement de personnes juridiquement incapables. Si le consentement vise avant tout à protéger l'autonomie de l'être humain, et si les personnes incapables de le donner sont par définition dépourvues d'autonomie[296], il paraît en effet illogique de l'exiger dans leur cas. Il ne faut pas pour autant nier la fonction morale du consentement donné par le mineur dont la maturité d'esprit est suffisante, ou encore par les parents ou les tuteurs du donneur potentiel. Les mineurs doués de discernement peuvent avoir l'autonomie que le consentement vise à protéger. De plus, il est de toute évidence souhaitable de défendre les incapables et les personnes vulnérables, en demandant à un proche soucieux de leur bien-être d'apprécier les risques et les avantages. L'exigence d'une appréciation indépendante ou d'un consentement par procuration serait dès lors de nature à protéger les patients incapables contre tout préjudice, à prévenir le dol ou la contrainte, et à encourager les professionnels de la santé à la circonspection[297].

Lorsqu'un donneur potentiel n'a pas l'autonomie que suppose le consentement, quel peut être le fondement moral du prélèvement ? Comme dans le cas des individus capables de consentement, le principe de la bienfaisance amène à conclure que le don peut être justifié si les avantages raisonnablement prévisibles pour le donneur l'emportent sur les préjudices possibles. L'accent ainsi mis sur la protection du donneur contribue à garantir qu'on ne prélève pas des organes sur des personne incapables de donner leur avis. Le fait de centrer l'évaluation sur les avantages véritables diminue aussi le risque qu'elle serve à masquer des préjugés concernant la « valeur sociale » de la personne incapable.

Peut-on vraiment affirmer que des enfants et des personnes atteintes de déficience mentale tirent profit du don de leurs organes ? Une importante dose de scepticisme[298] ou une présomption réfutable[299] contre ces interventions, pourraient s'avérer des armes efficaces contre les motivations cachées, mais l'opportunité du don demeure incontestable

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294. Comparer CRMC, *op. cit.*, note 118, pp. 28-33, et Barry HOFFMASTER, « The Medical Research Council's New Guidelines on Research Involving Human Subjects: Too Much Law, Too Little Ethics » (1989), 10 *Health L. Can.* 146.

295. Voir CRD, *L'expérimentation biomédicale sur l'être humain*, Document de travail n° 61, Ottawa, la Commission, 1989, pp. 44-47 (où la Commission recommande l'adoption d'une loi fédérale en vue de réglementer la recherche médicale non thérapeutique sur les enfants).

296. Voir CRMC, *op. cit.*, note 118, p. 29 (« Par définition, un sujet légalement incapable n'est pas autonome et ne peut donner un consentement valide du point de vue juridique ou éthique »).

297. Voir A.M. CAPRON, *loc. cit.*, note 281.

298. Voir P. RAMSEY, *op. cit.*, note 243, p. 172.

299. Rodney K. ADAMS, « Live Organ Donors and Informed Consent » (1987), 8 *J. Legal Med.* 555, 582.

dans certains cas. Un tribunal du Québec a récemment autorisé un enfant de cinq ans à faire don de sa moelle osseuse à son frère atteint d'un cancer[300]. Dans les premiers temps des transplantations rénales, des tribunaux du Massachusetts ont autorisé des dons entre jumeaux mineurs[301]. Dans l'une des principales affaires où il était question des avantages psychologiques pour le donneur, un tribunal américain a évalué les préjudices et les avantages dans le cas du don d'un rein par une personne atteinte de déficience mentale à son frère, et il a conclu que [TRADUCTION] « le bien-être du donneur serait davantage mis en péril par la perte de son frère que par le prélèvement d'un rein[302]. » Ainsi, le fait de considérer l'existence humaine dans une perspective plus large, pour l'évaluation des risques et des avantages, conduit parfois à une conclusion sensiblement différente que si l'on ne s'intéresse qu'à la dimension physique de la personne.

Mais si l'on estime, comme l'ont fait les tribunaux dans ces affaires, que les avantages psychologiques sont moralement pertinents[303], il reste à déterminer le poids relatif qu'il convient de leur accorder. Les évaluations risques-avantages doivent être réalisées dans le cadre de situations concrètes. Or, tous ne s'entendent pas sur la possibilité d'effectuer de telles comparaisons, et cette divergence d'opinions aide à séparer ceux qui autoriseraient le prélèvement d'organes sur des enfants et des personnes atteintes de déficience mentale, et ceux qui ne l'autoriseraient pas. Moralement, la différence est la suivante : les premiers mettent l'accent sur le contexte, les seconds sur les principes. Et sur le plan juridique, c'est l'opposition entre l'équité et l'application stricte des règles[304].

Les tenants de l'approche « contextuelle » ont confiance dans la capacité des êtres humains de discerner ce qui est bon ou préférable dans des circonstances particulières. Ainsi, en matière de transplantations, certains analystes considèrent les décisions fondées sur la théorie des avantages psychologiques comme [TRADUCTION] « des jugements [. . .] caractérisés par l'humanité et la compassion plutôt que par le respect aveugle d'un principe ou d'un critère[305]. » Leurs adversaires dénigrent la théorie en question, la qualifiant de norme spéculative et peu fiable[306] liée à l'éthique situationnelle et à une justice primitive.

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300. Voir *Cayouette* et *Mathieu*, *infra*, note 380.

301. William J. CURRAN, « A Problem of Consent: Kidney Transplantation in Minors » (1959), 34 *N.Y.U. L. Rev.* 891.

302. *Strunk* c. *Strunk*, 445 S.W. 2d 145, 146 (Ky 1969). Voir cependant *In re Guardianship of Pescinski*, 226 N.W. 2d 180 (Wisc. 1975) (le tribunal a refusé d'autoriser qu'un rein soit prélevé sur un patient adulte incapable atteint de schizophrénie chronique pour être donné à sa sœur), modifié par *Re Guardianship of Eberhardy*, 307 N.W. 2d 881, 893, n. 13 (Wisc. 1981). Ces décisions ont été passées en revue récemment dans *Curran* c. *Bosze*, *infra*, note 535, 1326-1329.

303. Voir CRMC, *op. cit.*, note 118, p. 7 (« Les torts qui peuvent être causés sont nombreux et ils ne se limitent pas aux atteintes corporelles. Ils comprennent aussi la perte de dignité et de l'estime de soi, la culpabilité et le remords ou le sentiment d'être exploité et humilié »). Si les préjudices psychologiques sont moralement pertinents, et peuvent plaider contre la participation de sujets humains à des recherches médicales non thérapeutiques, les bienfaits psychologiques ne pourraient-ils pas militer en faveur du don ?

304. Voir ARISTOTE, *Éthique à Nicomaque*, 2e éd., trad. par J. Tricot, Paris, Librairie philosophique J. Vrin, 1967, livre V, ch. 10.

305. R. SCOTT, *op. cit.*, note 268, p. 121.

306. Voir R.K. ADAMS, *loc. cit.*, note 299, 579, n. 168.

À leur avis, il convient d'appliquer uniformément des règles ou des principes généraux afin d'échapper aux préjugés et à la subjectivité. La constance est selon eux la marque de la primauté du droit ainsi que d'une morale fondée sur des principes ; elle s'impose même s'il en résulte, dans certains cas, des décisions injustes, ou dont toute compassion est absente. Dans le cas du prélèvement d'organes, ils sont donc convaincus que les enfants et les personnes atteintes de déficience mentale devraient être traités de la même manière que les adultes. Il s'agit encore une fois d'une opposition qui découle en partie d'un débat philosophique fondamental.

III. Obligation morale de donner

Des valeurs éthiques comme l'autonomie de l'être humain et le principe de non-malfaisance nous protègent contre les prélèvements de tissus qui seraient effectués sur nous contre notre gré et nous causeraient un préjudice. Mais à l'inverse, peuvent-elles aussi nous obliger au don de tissus ? L'accent mis en Amérique du Nord sur l'altruisme, l'emploi du terme « don », sont à cet égard ambigus[307]. Ce terme traduit l'interdiction de rémunérer le don d'organes. Il connote également l'idée que le don de tissus humains aux fins de transplantation est un acte de charité — qu'un tel geste, s'il est moralement louable, ne constitue pas nécessairement une obligation morale[308].

Existe-t-il, en fait, une obligation morale de faire don de ses tissus ? De nombreux philosophes ont envisagé l'existence d'une obligation générale de faire du bien à autrui. Mentionnons en particulier le philosophe allemand du XVIII[e] siècle, Emmanuel Kant, qui s'est intéressé à la notion de bienfaisance[309]. L'idée d'une obligation morale d'aider les autres a inspiré une lignée philosophique respectable depuis lors. En fait, les théories fondées sur la justice et le contrat social pourraient donner à penser qu'une personne doit être disposée à donner pour avoir le droit de recevoir. Toutefois, comme nous le verrons, la principale difficulté tient moins à la valeur de l'argument qu'aux mesures concrètes qui semblent nécessaires à la mise en œuvre d'une obligation de donner.

Kant fait reposer le devoir d'agir sur la maxime selon laquelle nous avons tous parfois besoin d'autrui :

> [Un homme] à qui tout sourit, mais qui voit des hommes (qu'il pourrait soulager) aux prises avec l'adversité, se dit à lui-même : Que m'importe ? Que chacun soit aussi heureux qu'il plaît au ciel ou qu'il peut l'être par lui-même, je ne l'empêcherai en rien ; je ne lui porterai pas même envie ; seulement je ne suis pas disposé à contribuer à son bien-être

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307. Voir David A. PETERS, « An Individualistic Approach to Routine Cadaver Organ Removal » (1988), *69 Health Progress* 25. Voir également *supra*, note 239.

308. Voir P. RAMSEY, *op. cit.*, note 243, pp. 185-186 ([TRADUCTION] « Les dons ne sont pas des droits que l'on peut revendiquer, ni des obligations que l'on peut imposer »).

309. Voir Immanuel KANT, *Fondements de la métaphysique des mœurs*, trad. par J. Muglioni, Paris, Bordas, 1988.

> et à lui prêter secours dans le besoin ! [. . .] Mais [. . .] il est impossible de vouloir qu'un tel principe soit partout admis comme une loi de la nature. Une volonté qui le voudrait se contredirait elle-même, car il peut se rencontrer bien des cas où l'on ait besoin de la sympathie et de l'assistance des autres, et où l'on se serait privé soi-même de tout espoir d'obtenir les secours qu'on désirerait, en érigeant volontairement cette maxime en une loi de la nature[310].

Il faut souligner trois choses au sujet de cet argument. Premièrement, Kant fait une distinction entre l'obligation de ne pas causer de préjudice à autrui et l'obligation de l'aider. La première constitue indéniablement une condition morale impérieuse — elle est au cœur de la loi, de la morale et de l'éthique médicale. Mais dans quelle mesure la morale va-t-elle au-delà de cette obligation négative minimale pour imposer une obligation positive d'aider autrui ? Tous ne s'entendent pas la-dessus. Deuxièmement, Kant voyait-il là de nobles règles d'or sociales ou de simples appels en faveur de l'intérêt personnel bien compris ? Troisièmement, aucune obligation morale de bienfaisance n'est pour Kant absolue — elles sont laissées à notre discrétion[311]. L'obligation générale de bienfaisance peut donc s'accomplir de nombreuses façons ; elle n'emporte pas nécessairement l'obligation morale de faire don de ses tissus à ceux qui en ont besoin.

Comment alors peut-on conclure à l'existence d'une obligation morale de donner, s'agissant des tissus humains ? Deux stratégies dominantes interprètent différemment l'argument de Kant. La première, s'appuyant sur le génie de l'individualisme, plaide en faveur d'une obligation morale de donner ses tissus après la mort[312]. Cette stratégie est fondée sur la prudence[313]. Les êtres rationnels qui voient à leur propre intérêt reconnaissent l'obligation de ne pas causer de préjudice à autrui parce que cette obligation leur permet de vivre sans la menace de préjudice causé par autrui. Un raisonnement semblable[314] peut constituer le fondement d'une obligation de faire du bien à autrui :

> [TRADUCTION]
> [L]e même raisonnement amènerait les individualistes à adopter la règle suivant laquelle on est tenu de porter secours à la personne en péril sans risque pour soi. Une telle règle exige que les individualistes renoncent, lorsqu'ils voient une personne en péril, à leur liberté de décider s'ils viendront ou non à son aide. Le témoin est tenu de donner à la victime toute aide utile qui ne présente que peu de frais ou de risques pour lui. [. . .] Le rapport avantages-risques rendrait cette règle très attirante pour les individualistes. En acceptant de subir de légers inconvénients lorsqu'ils voient une personne en danger, ils gagnent l'assurance qu'ils seront secourus en cas de péril. La protection promise leur permet de mieux planifier leurs activités, ce qui accroît la liberté[315].

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310. *Id.*, pp. 54-55.

311. *Id.*, p. 52, n. 1.

312. D.A. PETERS, *loc. cit.*, note 307, 25.

313. *Ibid.* ([TRADUCTION] « Les êtres rationnels qui font primer la liberté trouveraient prudent d'accepter l'obligation de porter secours à autrui sans risque pour soi et l'obligation de consentir au prélèvement de ses organes après la mort, pour le motif que leur liberté et leur bien-être personnels seront vraisemblablement mieux protégés et favorisés dans une société qui obéit à ces règles que dans une société qui s'en passe. »).

314. Voir Robert LIPKIN, « Beyond Good Samaritans and Moral Monsters: An Individualistic Justification of the General Legal Duty to Rescue » (1983), 31 *U.C.L.A. L. Rev.* 252.

315. D.A. PETERS, *loc. cit.*, note 307, 26.

Même si le fait de prévoir les situations d'urgence semble être une conception bizarre de la liberté, il est permis de croire que l'intérêt personnel encouragerait beaucoup de personnes à adhérer à un contrat social comportant une obligation morale de bienfaisance. Une telle logique pourrait également justifier, en matière de prélèvement des tissus après la mort, la présomption de consentement ou le prélèvement discrétionnaire. En résumé, des personnes rationnelles et soucieuses de leur propre intérêt pourraient privilégier à cet égard l'établissement par l'État d'une politique qui maximiserait leurs chances de bénéficier d'une transplantation de leur vivant, s'ils en ont besoin, au risque de voir leurs tissus prélevés après leur mort[316].

La deuxième stratégie est fondée sur une conception moins individualiste, tenant davantage de la règle d'or selon laquelle il convient d'aider autrui, simplement parce que c'est bien ; c'est la notion du bon Samaritain. L'attrait moral est convaincant à l'extrême dans les exemples suivants :

> [TRADUCTION]
> La coiffure d'une femme prend feu, il y a de l'eau tout près : un homme, au lieu d'aider à éteindre le feu, regarde et s'esclaffe. Un homme ivre tombe face contre terre dans une mare d'eau et il risque d'étouffer ; il suffirait pour lui sauver la vie de lui relever un peu la tête de côté : un autre homme assiste à la scène sans intervenir. De la poudre à fusil est éparpillée dans une pièce ; un homme y entre avec une bougie allumée : une autre personne, connaissant le danger, le laisse entrer sans le prévenir[317].

Si l'obligation morale d'agir en bon Samaritain est facile à comprendre, la difficulté se situe au niveau de la troisième étape de l'éthique pratique, soit l'élaboration d'une politique propre à permettre l'application concrète d'une solution théorique intéressante. Du reste, cette difficulté est souvent invoquée pour expliquer que la loi s'écarte de la morale à cet égard[318]. Comment, dans la pratique, tenir compte du cas des mauvais Samaritains dans les textes régissant le prélèvement de tissus humains ?

Une solution a été tentée à Singapour. Dans une loi de 1987 qui établit une présomption de consentement à l'égard du prélèvement des reins après la mort, on réserve un traitement particulier aux personnes opposées aux dons :

> [TRADUCTION]
> Pour l'application de la loi proposée, les musulmans sont présumés s'opposer [pour des motifs religieux] et ils sont donc assimilés aux autres opposants. [. . .] Ces personnes sont rangées dans une catégorie de priorité moindre, lorsqu'elles ont besoin d'une greffe de rein[319].

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316. Voir J.L. MUYSKENS, *loc. cit.*, note 252, 97.

317. J.H. BURNS et H.L.A. HART (dir.), *An Introduction to the Principles of Morals and Legislation*, Londres, Athlone, 1970, p. 293, n. u.

318. Pour une discussion plus approfondie sur le devoir légal de porter secours, voir *infra*, pp. 103-106.

319. Voir T.K.K. IYER, « Kidneys for Transplant — "Opting Out" Law in Singapore » (1987), 35 *Forensic Sci. Int'l* 131, 135. Les musulmans forment 16 % de la population de Singapour. *Id.*, 132. Voir la loi intitulée *Loi de 1987 relative à la transplantation d'organes humains*, dont le texte figure dans (1990), 41:2 *R.I.L.S.* 278. Voir aussi D.A. PETERS, *loc. cit.*, note 307, 27.

Essentiellement, la loi institue deux catégories de personnes pour la sélection des bénéficiaires de greffes, selon le critère du consentement au prélèvement. Est-ce équitable ?

La réponse dépend sans doute de la façon dont on réagit à l'idée que les plus disposés à donner devraient être les premiers bénéficiaires des transplantations[320]. Le fondement moral de cette thèse est-il l'individualisme contractuel intéressé, la bienfaisance humanitaire, ou les deux à la fois ?

Des difficultés se posent aussi sur le plan moral et sur le plan pratique dès qu'on entend contraindre une personne à s'acquitter de l'obligation morale de donner des tissus de son vivant. Dans une affaire souvent citée à ce propos, un patient atteint de leucémie avait tenté d'obtenir une ordonnance judiciaire obligeant son cousin à lui donner de la moelle osseuse[321]. Les textes instituant une obligation de porter secours à une personne en péril dispensent normalement d'agir lorsque cela présente des risques appréciables[322]. Mais le juge, en l'occurrence, n'a même pas eu à se prononcer sur cet aspect du problème :

> [TRADUCTION]
> Suivant une règle constante de la common law, nul n'est légalement tenu d'aider une autre personne ni de prendre des mesures en vue de la sauver ou de lui porter secours [...] Si notre droit *obligeait* le défendeur à se soumettre à une atteinte à l'inviolabilité de son corps, tous les concepts et les principes sur lesquels notre société est fondée en seraient modifiés. Cela serait contraire au principe de l'inviolabilité de la personne — on n'ose imaginer où serait tirée la ligne[323].

Le tribunal, tout en reconnaissant semble-t-il que le donneur potentiel avait l'obligation morale d'aider son cousin en danger[324], a refusé de traduire cette obligation morale en une obligation juridique. Cette décision donne à penser que, lorsqu'il y a opposition réelle et pratique entre les principes moraux de la bienfaisance et de l'autonomie, on a peu de chances de voir le premier l'emporter.

IV. Le corps et la personne

Nous avons, vu, dans la première section de ce chapitre, qu'il existe plusieurs points de vue sur le prélèvement de tissus sur des cadavres, et que ces points de vue sont intimement liés à la façon dont chacun conçoit la relation entre le corps et la personne. Ceux pour qui la personne ne vit pas simplement dans un corps mais est « un corps vivant » accordent beaucoup de respect au cadavre, parce qu'il constitue l'emblème de l'humanité et de la personne. Lorsque la personne et le corps ne font qu'un, le respect dû aux personnes s'étend

320. Voir D.A. PETERS, *loc. cit.*, note 307, 27-28.

321. *McFall* c. *Shimp*, *infra*, note 533. Voir également R. SCOTT, *op. cit.*, note 268, pp. 127-139.

322. Voir l'analyse, *infra*, pp. 103-106.

323. *McFall* c. *Shimp*, *infra*, note 533, 91.

324. Voir cependant T.L. BEAUCHAMP et J.F. CHILDRESS, *op. cit.*, note 236, p. 154.

au corps et persiste après la mort. On refusera alors de considérer ou de traiter le corps humain comme une réserve de pièces pouvant servir à remettre à neuf d'autres corps humains.

En revanche, ceux qui n'admettent qu'un lien ténu entre le corps et la personne considèrent que le corps est nécessaire à l'expression et à la facilitation de la personne, sans pour autant être revêtu de quelque valeur inhérente. Selon eux, le corps n'ayant de valeur qu'en tant qu'instrument, il est possible de s'en servir pour aider d'autres personnes. Cette conception s'accorde mieux avec le régime du prélèvement discrétionnaire : [TRADUCTION] « Puisque l'identité de la personne et du corps est accessoire, on n'a pas à demander une autorisation à la famille, ou au donneur avant son décès, pour prélever, pour une bonne cause, ses organes, son sang ou ses tissus[325] ». Nous explorerons dans les paragraphes suivants les sources philosophiques de ces points de vue opposés, et nous en étudierons les incidences sur les notions de commerce et de propriété, s'agissant du corps humain.

On retrouve dans plusieurs traditions religieuses le concept de la personne en tant qu'être incarné dans un corps. Un courant de l'éthique protestante adhère à [TRADUCTION] « la vision très réaliste de la vie de l'homme qui n'est que chair[326]. » L'éthique traditionnelle juive, elle aussi, [TRADUCTION] « exprime cet intérêt pour l'existence incarnée de l'homme et affirme joyeusement l'intégrité de la chair[327]. » De telles conceptions peuvent entraîner des restrictions rigoureuses d'ordre religieux et moral, à propos de l'utilisation du corps après la mort[328].

La thèse suivant laquelle la personne est distincte du corps tire quant à elle son origine de la pensée laïque du XVII^e siècle :

> [TRADUCTION]
> [. . .] le mentalisme et le dualisme de l'esprit (âme et personne) et du corps défendus par Descartes [. . .] sont endémiques dans la mentalité moderne ; il s'agit d'une épidémie qui affecte presque toutes les conceptions contemporaines. Notre culture est déjà prête à la technocratisation de la vie du corps en une collection de parties dans lesquelles la conscience réside d'une quelconque manière pour un temps. [. . .] Le dualisme contagieux de la culture moderne a déjà placé [l'homme], en tant que maître spirituel, trop loin au-dessus de sa vie physique. Pour la plupart d'entre nous, une partie du corps, ou la vie corporelle dans sa totalité, n'est déjà qu'une chose présente dans le monde, qu'il faut éviter d'identifier à la personne[329].

La pensée scientifique moderne, pierre angulaire de la médecine que nous connaissons, est le produit du Siècle des lumières. Peut-être la science et la médecine auraient-elles

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325. W.F. MAY (1985), *loc. cit.*, note 245, 39.

326. P. RAMSEY, *op. cit.*, note 243, p. 187.

327. *Ibid.* Voir également W.F. MAY (1985), *loc. cit.*, note 245, 39 (résumé des points de vue religieux au sujet de la personne et du corps).

328. Voir *infra*, pp. 162-165.

329. P. RAMSEY, *op. cit.*, note 243, p. 193.

pu progresser même sans le dualisme cartésien de l'esprit et du corps, mais elles en sont fortement imprégnées. On peut en fait attribuer en grand partie le succès de la médecine moderne au souci du corps. Certains penseurs imputent même à la science certains problèmes moraux contemporains :

> [TRADUCTION]
> Au fond du problème [. . .] se trouvent l'hégémonie de la science moderne de la nature et sa vision de la nature, à laquelle adhèrent même les partisans de la notion de personne (*personhood*) et de la subjectivité, étant donné que leur tentative de situer la dignité humaine dans la conscience et l'esprit suppose que le corps vivant subconscient, sans parler de la nature en général, est en soi tout à fait dénué de quelque dignité ou de quelque signification[330].

La théorie morale moderne n'est pas immunisée contre le dualisme du corps et de l'esprit qui s'est répandu dans la pensée occidentale depuis des siècles. Certains critiques maintiennent que les théoriciens de la notion de personne, de la conscience et de l'autonomie considèrent l'être humain essentiel comme volonté et raison pures, comme si la vie du corps ne comptait pour rien, ou même n'existait pas[331]. Une école philosophique, celle de la tradition analytique anglo-américaine, reprend à son compte ce dualisme cartésien.

Une autre école, la tradition phénoménologique continentale, vise résolument, au contraire, à faire disparaître la dichotomie corps-esprit[332]. Elle rejette la méthodologie scientifique caractérisée par l'objectivation et le réductionnisme et, se fondant sur l'expérience subjective, estime que nous sommes des être incarnés dans un corps[333]. Pour les phénoménologistes, le fractionnement de l'expérience humaine en des champs physiques et mentaux distincts est [TRADUCTION] « un artifice, nécessaire à l'étude scientifique de l'homme, mais qui entrave la pensée philosophique et l'action morale[334]. » Une fois le dualisme rejeté, le corps n'est [TRADUCTION] « ni un objet plongé dans un monde matériel, ni une conscience posant le monde[335] » ; il est plutôt [TRADUCTION] « une structure qui permet l'apparition à la fois du monde et de la conscience[336] » :

> [TRADUCTION]
> [C]e corps objectivé a une place bien particulière dans nos perceptions. Ce n'est que parce que nous le traînons avec nous comme un objet matériel, que nous sommes capables de prêter attention à d'autres objets. La même ambiguïté se présente lorsque nous sentons

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330. Leon R. KASS, « Thinking About the Body » (1985), 15:1 *Hast. Cent. Rep.* 20.

331. *Ibid.* Le dualisme se manifeste également dans les critères éthiques ayant trait à la notion de « personne ». Voir G.B. WHITE, *op. cit.*, note 91, p. 132.

332. Wim J. VAN DER STEEN et P.J. THUNG, *Faces of Medicine*, Boston, Kluwer, 1988, p. 198.

333. *Id.*, p. 150.

334. *Id.*, p. 119.

335. *Id.*, p. 155.

336. *Ibid.* Voir également *ibid.*, p. 153 ([TRADUCTION] « au cours des différents siècles, le corps a pris la forme d'un artefact (cf. anatomie du XIV^e^ siècle, physiologie expérimentale de Harvey, découverte au XIX^e^ siècle de la radiophotographie et des réflexes spinaux). Durant cette évolution, le corps [. . .] naturel de l'homme a graduellement été vidé de son âme et de son sens, et la matière a remplacé l'essence. Le dualisme de Descartes n'était que la reconnaissance formelle des changements subis par le corps, bien avant que les rayons Roentgen et les réflexes ne complètent le processus »).

que les choses ne sont pas « données » à notre perception, mais que nous les « vivons ». Pourtant, lorsque nous les « vivons », nous leur donnons la forme d'une réalité objective parce que notre corps est ajusté [...] au monde. Ainsi, le corps humain est, pour soi, un phénomène primordial, mais il est également rattaché, en soi, à un monde naturel[337].

Deux conceptions s'opposent donc au sujet de la relation entre le corps et la personne. Et selon qu'on opte pour l'une ou pour l'autre, on aura un point de vue différent sur les problèmes de la propriété et du commerce du corps humain.

A. Le corps, la personne et la propriété

Quelles implications éthiques entraîne le fait d'envisager le corps humain comme un bien, une chose susceptible d'appropriation ? Le problème est complexe :

[TRADUCTION]
Mon corps appartient peut-être à Dieu, peut-être m'appartient-il ; mais entre vous et moi, il est sans aucun doute à moi. Et pourtant, j'hésite. Quel genre de *bien* est mon corps ? Est-il à moi ou est-il *moi* ? Peut-il être aliéné, comme mes autres biens, comme mon automobile ou même mon chien ? Et selon quel principe puis-je revendiquer des *droits* de propriété sur mon corps ? Ai-je travaillé pour l'obtenir ? Moins que ne l'a fait ma mère, et pourtant il ne lui appartient pas. Puis-je le réclamer selon le principe du mérite ? C'est douteux : je l'avais avant de pouvoir prétendre l'avoir mérité. Puis-je le considérer comme un cadeau — qu'il y ait ou non un donneur ? De quelle façon possède-t-on et utilise-t-on un cadeau ? Puis-je en disposer à ma guise — surtout si je ne peux répondre à ces questions[338] ?

On voit à quel point le concept de propriété peut être relatif et indéterminé. Dans certains contextes, et pour certaines raisons, il peut s'avérer opportun d'envisager le corps comme un bien. Dans d'autres contextes et pour d'autres raisons, ce n'est pas opportun. Il est donc essentiel de circonscrire ces contextes et ces raisons.

Qu'est-ce qu'un bien ? Du point de vue de l'éthique, il n'y a pas de réponse simple, mais seulement une série d'associations et de distinctions, accompagnées de jugements sur le point de savoir si l'existence de certaines caractéristiques suffit pour qu'on appelle une chose « un bien ». On a pu dresser, par exemple, une liste des onze conséquences juridiques du droit de propriété :

[TRADUCTION]
La propriété comprend le droit de posséder, le droit d'utiliser, le droit de gérer, le droit aux fruits de la chose, le droit au capital, le droit à la sécurité, les droits ou droits incidents de transmission et d'absence de terme, l'interdiction d'utiliser d'une façon préjudiciable à autrui, l'assujettissement aux règles d'exécution et le droit à la jouissance résiduelle[339].

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337. *Id.*, p. 155.

338. L.R. KASS, *loc. cit.*, note 330, 23.

339. A.M. HONORE, « Ownership », dans A.G. Guest (dir.), *Oxford Essays in Jurisprudence*, 1st ser., Oxford, Clarendon, 1961, p. 107, à la page 113.

Si, à l'égard de mon corps, j'ai un droit de possession, d'utilisation et de gestion, un droit à la sécurité, et si par ailleurs il m'est interdit de l'utiliser d'une manière préjudiciable à autrui, est-ce que je peux m'en prétendre le « propriétaire » ? Peut-être bien, mais dans ce cas, l'affirmation devrait être tempérée, parce qu'il ne s'ensuit pas nécessairement que j'ai d'autres « droits incidents », notamment le droit au « capital » de mon corps ou le droit de l'aliéner. Pour que la réponse soit complète, donc, il faudrait dire : « oui, je suis propriétaire de mon corps, dans un sens, ou à certains égards ».

Cette analyse nous aide à comprendre « dans quels sens et à quels égards » chacun est propriétaire de son corps. En particulier, elle montre qu'il faut résister à la tentation de faire équivaloir propriété et commerce. Il est tentant, pour ceux qui souhaitent empêcher la commercialisation des organes, de prétendre que le corps humain n'est pas un bien. Mais comment alors expliquer le *don* d'organes ? Si ce rein ne m'appartient pas, de quel droit puis-je le donner[340] ? Il faut pousser l'analyse plus loin, pour reconnaître qu'un droit d'aliénation peut être rattaché aux organes et aux tissus corporels, sans qu'on puisse conclure par ailleurs à l'existence d'un droit au capital.

Mais cette façon d'aborder la question n'est pas sans faiblesses. Elle permet de poser les problèmes, sans pour autant indiquer de solutions. À la question : « Le corps est-il un bien ? », elle donne une réponse lucide, qui approuve le don mais non la vente d'organes ou de tissus corporels. Mais elle ne permet pas de répondre aux questions d'ordre éthique sous-jacentes parce qu'elle ne précise pas au nom de quels arguments moraux le don serait permis, mais non la vente. Elle offre bien peu d'indications sur les raisons d'ordre moral pour lesquelles on peut être propriétaire de son corps dans un sens, mais non dans un autre :

> [TRADUCTION]
> Il est clair que ce n'est pas en contemplant le sens du mot « chose » que l'on saura quels sont les intérêts protégés conçus en termes de propriété. Lorsque le législateur ou les tribunaux estiment qu'un intérêt devrait être aliénable et transmissible, ils le chosifient et disent qu'il est susceptible d'appropriation, que c'est un bien — ce n'est pas parce qu'ils sont convaincus au départ que cet intérêt correspond à la définition appropriée du mot « chose ». On fait sans doute fausse route en voulant analyser le concept de « chose »[341].

C'est en se fondant sur des considérations morales sérieuses qu'on doit déterminer quels « droits incidents » du droit de propriété devraient être rattachés à tel ou tel objet.

Pourquoi n'y a-t-il pas lieu de considérer le corps comme un bien ordinaire ? On pourrait répondre, d'abord, que cette idée heurte les concepts d'autonomie personnelle et de dignité humaine. La notion de bien a toujours été associée à des choses, et non au corps humain. Assimiler celui-ci à une chose déshumanise l'existence humaine ; à l'extrême, cela conduit à l'idée répugnante que les être humains sont susceptibles d'appropriation. Cette réponse est axée à la fois sur le dualisme chose-personne[342] et sur l'idée que les

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340. Voir J.F. CHILDRESS, *loc. cit.*, note 249, 89, 100 ([TRADUCTION] « Nous pensons souvent aux biens uniquement dans le sens commercial, mais même les dons de parties du corps humain supposent une certaine notion de bien »).

341. A.M. HONORE, *loc. cit.*, note 339, 130.

342. Voir M.J. RADIN, *infra*, note 460, 1891, au sujet des arguments de Kant.

parties du corps humain sont le reflet de notre conception de la personne. C'est là que les objections à la vente et à l'acquisition de tissus humains trouvent leur fondement.

Il est donc quelque peu malaisé d'expliquer d'une manière générale ce qu'il y a de condamnable dans l'idée d'« aliéner » son propre corps. La notion d'« aliénation », tout comme celles de « bien » et de « propriété », peut en effet signifier plusieurs choses. « Aliéner » un rein en le donnant en vue d'une transplantation est un geste louable ; l'« aliéner » en le vendant est une transaction suspecte. Par conséquent, l'enjeu moral ne porte pas sur l'aliénation en soi, mais bien sur l'aliénation dont la contrepartie est d'ordre pécuniaire. Quelles sont alors les objections de fond à l'achat et à la vente de tissus humains ?

B. Le corps, la personne et le commerce

La pénurie généralisée des dernières années a suscité un débat, à l'échelle nationale et internationale, sur le problème de l'achat et de la vente de tissus humains[343]. Certains analystes voient dans la vente de tissus un moyen de remédier à cette pénurie[344]. D'autres s'y opposent résolument, que les tissus soient prélevés avant la mort ou après[345]. Certains, enfin, tout en se préoccupant des abus possibles, ne s'opposent pas en principe au versement d'argent contre des tissus humains. La théologie morale catholique se situe sans doute dans ce moyen terme. Le pape Pie XII, par exemple, se fondant sur une analogie avec la vente du sang, a refusé de condamner la vente de tissus humains :

> [TRADUCTION]
> Faut-il, comme on le fait souvent, refuser par principe tout dédommagement ? Cette question demeure sans réponse. Il est indéniable que de sérieux abus pourraient se produire si le paiement était exigé. Mais ce serait aller trop loin que de déclarer immorale toute acceptation ou toute exigence de paiement. Il s'agit d'une situation semblable à celle des transfusions sanguines. Il est louable que le donneur refuse une récompense : ce n'est pas nécessairement une faute de l'accepter[346].

Quels sont donc, au regard de la morale, les aspects positifs et les aspects négatifs de la vente de tissus humains ? Ils correspondent dans une large mesure aux considérations juridiques et pratiques étudiées plus loin[347]. Les partisans de cette solution tendent à fonder leur opinion sur la valeur éthique de la préservation de la vie, en invoquant les conséquences visibles de l'altruisme pur. Selon eux, la vente de tissus réduirait sensiblement la pénurie actuelle ; elle accroîtrait l'offre de tissus prélevés sur des cadavres, ce qui

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343. Sur les préoccupations à l'échelle internationale, voir *infra*, pp. 186-187.

344. Voir David A. PETERS, « Marketing Organs for Transplantation » (1984), 13:1 *Dialysis and Transplantation* 40; Henry HANSMANN, « The Economics and Ethics of Markets for Human Organs » (1989), 14:1 *J. Health Pol. Pol'y L.* 57; Lori B. ANDREWS, « My Body, My Property » (1986), 16:5 *Hast. Cent. Rep.* 28.

345. Voir P. RAMSEY, *op. cit.*, note 243, p. 213.

346. *Papal Teachings: The Human Body*, Boston, St. Paul Editions, 1960, cité dans G.B. WHITE, *op. cit.*, note 91, p. 142. Voir aussi Charles Joseph MCFADDEN, *Medical Ethics*, 6e éd., Philadelphie, F.A. Davis, 1967, p. 297.

347. Voir *infra*, pp. 95-97.

diminuerait la nécessité de prélever des organes sur les personnes vivantes, et partant les risques associés à ces interventions chirurgicales. En outre, disent-ils, une plus grande offre favoriserait la compatibilité immunologique et diminuerait ainsi le nombre de rejets. Par ailleurs, tout risque d'abus grave pourrait être maîtrisé par la limitation ou la réglementation du marché[348].

Ceux qui s'opposent à la vente de tissus fondent leur opinion sur des arguments relevant du formalisme et sur la prise en compte de certaines conséquences. Ils font valoir, en particulier[349], qu'elle mettrait fin à l'altruisme public, en diminuant la quantité de tissus donnés librement en vue de leur transplantation[350] ; et qu'elle battrait en brèche la justice sociale, en permettant à un marché libre d'attribuer les tissus selon la capacité de payer : les plus démunis seraient souvent incapables de verser les sommes exigées et se verraient ainsi refuser l'accès à des traitements susceptibles de leur sauver la vie[351].

Une de leurs principales objections transcende l'analyse des inconvénients et des avantages. Elle repose en effet sur l'idée que la vente de tissus humains est intrinsèquement immorale, déshumanisante et qu'elle porte atteinte au respect dû aux personnes. L'argument, d'ordre formaliste, s'appuie sur la philosophie morale de Kant :

> Ce qui n'a que du prix peut être remplacé par quelque *équivalent* ; mais *ce qui est au-dessus de tout prix et ce qui, par conséquent, n'a pas d'équivalent, voilà ce qui a de la dignité.* [...]
>
> Or, la moralité est précisément cette condition qui seule peut faire d'un être raisonnable une fin en soi. [...] La moralité et l'humanité, en tant qu'elle est capable de moralité, voilà donc ce qui seul a de la dignité[352].

La dignité humaine est le fondement du respect dû à toutes les personnes, qui sont de ce fait inestimables.

Dans quelle mesure cette dignité humaine intrinsèque s'étend-elle à la personne physique ? Certains estiment que le corps humain n'est pas revêtu de cette protection morale apparente. Pour Kant, c'est en tant qu'êtres rationnels que les personnes possèdent une

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348. *Ibid.* Voir également Theodore SILVER, « The Case for a Post-Mortem Organ Draft and a Proposed Model Organ Draft Act » (1988), 68 *B.U. L. Rev.* 681, 699-703. Chose intéressante, Silver conteste l'hypothèse selon laquelle la vente d'organes réduirait la pénurie actuelle. *Id.*, 701.

349. Voir également *infra*, pp. 95-97.

350. *Ibid.*, R.M. TITMUSS, *op. cit.*, note 244, pp. 225-229. Si une diminution du nombre de tissus donnés par altruisme était probable, alors que le nombre de tissus en général augmenterait, les probabilités opposeraient moralement les avantages moins tangibles et moins quantifiables de l'altruisme et un régime mixte de prélèvement des tissus humains répondant plus efficacement aux besoins thérapeutiques.

351. Thomas H. MURRAY, « On the Human Body as Property: The Meaning of Embodiment, Markets, and the Meaning of Strangers » (1987), 20 *U. Mich. J. L. Ref.* 1055, 1084. Ceux qui favorisent la vente répondent que l'avantage consistant dans l'accroissement du nombre de vies sauvées l'emporterait sur les éventuelles injustices, et qu'un marché réglementé pourrait répondre à ces inquiétudes. Voir *infra*, ch. III, section I.C(2).

352. I. KANT, *op. cit.*, note 309, p. 70 [mis en italiques par nos soins]. La notion de « prix » a ici un sens plus large — elle ne se limite pas au prix déterminé sur un marché.

dignité et ont droit au respect. Or, si la justification du respect moral se trouve dans la rationalité, et si cette rationalité a son siège dans une partie distincte du corps humain, l'esprit par exemple, le reste du corps se trouve dénué de toute valeur morale particulière. Il semble donc qu'en réduisant la moralité à la r ionalité, on aboutit à la dévalorisation du corps humain[353].

La pertinence de la préoccupation kantienne paraît par conséquent liée, elle aussi, aux diverses conceptions touchant la relation entre le corps et la personne. La force qu'on attribue à cette relation influe sur notre attitude quant à la question de savoir s'il est acceptable de considérer des éléments du corps humain comme des objets de commerce. Ceux pour qui le corps est un simple substrat de l'être estiment que la vente de tissus ne soulève en soi que peu de difficultés. Selon eux, rien ne s'oppose fondamentalement, sur le plan moral, à ce qu'on utilise le corps pour réaliser les fins de la personne. Comme le corps n'a de valeur qu'en tant qu'instrument, rien n'empêche d'attribuer un prix à cette valeur. En revanche, les adversaires du dualisme de l'esprit et du corps, qui identifient le corps et la personne, estiment que la dignité humaine s'étend à la totalité du corps humain, qu'elle rend inestimable :

> [TRADUCTION]
> Le différend entre ceux qui croient que la commercialisation du corps humain est justifiée et ceux qui pensent le contraire semble surtout opposer les tenants d'une conception dualiste de la séparation du corps (être physiologique matériel) et de l'esprit (être rationnel, immatériel), et ceux qui récusent cette conception[354].

Pour ceux qui, tout en étant sensibles à la conception kantienne, savent dans quelle mesure les versements d'argent contribuent déjà à favoriser et à accélérer les transplantations de tissus humains, des distinctions d'ordre pragmatique peuvent constituer un fondement moral permettant de tolérer une certaine contrepartie pécuniaire pour le don de tissus, sans qu'il y ait atteinte à la dignité humaine. En effet, on pourrait faire valoir que l'idée de dignité de la personne est tout à fait étrangère à certaines substances corporelles, qui ressemblent davantage à des « choses » :

> [TRADUCTION]
> Même si la vente de parties du corps humain, notamment les organes solides, pourrait s'avérer déshumanisante pour la société, il existe un débat quant à la question de savoir si la vente de toutes les productions biologiques du corps, y compris les tissus et les liquides éliminés par lui (les cheveux, l'urine...) ainsi que des tissus susceptibles de régénération (le sang, par exemple) est déshumanisante [...] En outre, certains partisans de la vente feraient une distinction entre les vendeurs vivants et les cadavres, et établiraient une exception pour les cas où il existe un conflit d'intérêts (par ex. la vente des fœtus avortés ou des tissus fœtaux). De plus, il serait possible de distinguer différents types de contreparties, comme les paiements directs et les incitatifs indirects. Par exemple, ne pourrait-on pas considérer comme tout à fait différents, le paiement direct d'une part, et de l'autre la prise en charge des dépenses médicales du donneur, la compensation de la perte de salaire du donneur vivant et le paiement des funérailles d'un donneur décédé[355] ?

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353. Voir G.B. WHITE, *op. cit.*, note 91, pp. 132-134, au sujet de J. FLETCHER et H.T. ENGELHARDT.

354. G.B. WHITE, *op. cit.*, note 91, p. 143.

355. J.F. CHILDRESS, *loc. cit.*, note 249, 101.

Ces distinctions sont-elles convaincantes sur le plan moral ? On pourra les juger utiles pour l'élaboration d'une politique, puisqu'elles permettent la recherche d'un « juste équilibre » ; mais leur fondement moral s'avère parfois bien fragile. Il semble difficile, par exemple, d'établir des critères qui, tout en étant valables du point de vue de l'éthique, permettent de distinguer les paiements directs et les incitations indirectes. Sur le plan des principes, on pourra juger qu'offrir de l'argent à une personne pour l'encourager au don de tissus n'est pas la même chose que de la rembourser de ses dépenses ; mais, en pratique, la différence s'estompe parfois. On peut s'opposer au paiement direct parce qu'il constitue une incitation abusive, et accepter le remboursement des dépenses parce qu'il ne s'agit pas d'une mesure d'incitation, mais d'une tentative pour supprimer des obstacles. La réalité sociale montre, toutefois, que le caractère incitatif d'une mesure tient autant à la situation de l'intéressé qu'à la somme offerte et à l'esprit dans lequel l'offre est faite. Par exemple, si l'on remet 250 $ aux personnes qui acceptent de participer à l'essai d'un médicament, la valeur économique de cette « contrepartie » n'est pas la même pour un professionnel libéral salarié et pour un étudiant sans le sou. Pour le premier, elle ne constitue pas vraiment un dédommagement, tandis que dans le cas du second, elle risque de se rapprocher d'une incitation abusive[356]. Certains analystes considèrent donc ces distinctions comme illusoires ou fictives[357].

Pourtant, une stratégie où l'on reconnaîtrait l'existence de diverses catégories de tissus humains, pour ensuite définir les conditions selon lesquelles il pourrait y avoir versement d'argent, permettrait sans doute de mieux tenir compte des différentes préoccupations d'ordre éthique, que la solution consistant à autoriser ou à interdire, purement et simplement, la vente sur un marché libre. Mais que le marché soit libre ou restreint, une question fondamentale subsiste : existe-t-il des solutions de rechange moins risquées au regard de l'éthique ? Vu les différentes objections d'ordre moral que suscite la vente de tissus humains, il serait malavisé de s'y exposer dans le cas où la société pourrait arriver aux mêmes résultats par d'autres moyens[358]. Cet argument a été utilisé d'une manière convaincante dans le cadre de l'expérience de « demande obligatoire » en cours au États-Unis[359]. Ceux qui s'opposent à la vente des tissus font ainsi valoir que, fût-elle *acceptable* sur le plan de l'éthique[360], il reste à prouver qu'elle est *préférable*, de ce point de vue, aux autres solutions envisageables, de l'altruisme au prélèvement discrétionnaire[361].

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356. Certains préféreraient peut-être le mot « contrainte ». D'autres font une différence entre les incitations financières et la contrainte. Voir H.J. McCLOSKEY, « Coercion: Its Nature and Significance » (1980), 18 *Southern J. Phil.* 335, 339. Certes, il est important de donner une qualification morale aux incitations abusives ou « irrésistibles », mais l'emploi du terme « contrainte » risque d'obscurcir les choses. Ce terme semble porter en lui une conclusion ; c'est-à-dire que si l'on tient une incitation pour moralement répréhensible, on la qualifiera de « contrainte », pour tirer parti des connotations morales négatives qui se dégagent du terme.

357. Voir, par exemple, T.H. MURRAY, *loc. cit.*, note 351, 1074. Voir également *infra*, ch. III, section I.C.(3).

358. J.F. CHILDRESS, *loc. cit.*, note 249, 100-101.

359. Voir A.M. CAPLAN, *infra*, note 987 ; c'est à Caplan qu'on doit le concept de la « demande obligatoire » utilisé aux États-Unis.

360. Pour se prononcer là-dessus, il est indispensable de décider à quel pourcentage de la demande (50 % ? 75 % ? 90 % ?) un régime de prélèvement doit permettre de satisfaire pour être jugé « suffisamment efficace ». Voir J.F. CHILDRESS, *loc. cit.*, note 249, 101. De même, qu'est-ce qu'une attente « raisonnable », pour les patients dont l'état nécessite une transplantation ?

361. *Id.*, 89. À un système d'achat et de vente, certains analystes préfèrent un système de crédits à la famille et le prélèvement discrétionnaire. Voir W.F. MAY (1973), *loc. cit.*, note 245, 4.

V. Élaboration d'une politique

Notre étude des étapes fondamentales de la bioéthique — identifier les valeurs en jeu, les soupeser et déterminer ensuite la politique souhaitable — nous amène à certaines conclusions sur l'élaboration d'une politique propre à faciliter et à accélérer le prélèvement de tissus humains à des fins thérapeutiques.

Premièrement, les valeurs qui sous-tendent et animent la politique établie en matière de prélèvement de tissus humains sont diverses et changeantes : il y a d'une part l'évidente volonté de sauver des vies et, d'autre part, d'autres valeurs auxquelles on accorde un grand prix — autonomie, justice, dignité humaine — ainsi que les obligations morales fondamentales de faire du bien à autrui et de ne lui causer aucun mal. Ces valeurs traduisent de grands concepts moraux, parfois bien abstraits. Bon nombre d'entre elles sont considérées comme fondamentales, mais seul un petit nombre sont jugées absolues ou prééminentes. C'est pourquoi elles peuvent se compléter ou contraire se disputer la prédominance, selon le régime de prélèvement envisagé.

Deuxièmement, la nature même des concepts moraux, des valeurs contradictoires et des débats philosophiques liés à la politique relative au prélèvement de tissus humains nous rappelle que, malgré les besoins médicaux criants de nos êtres physiques, notre identité réside en très grande partie dans nos pensées, nos convictions, nos valeurs. Nous avons vu que la façon dont, consciemment ou non, nous concevons la relation entre le corps et la personne détermine constamment notre réflexion et nos actes face au corps humain et au cadavre. La force que nous attribuons à cette relation, en fait, influe sur notre point de vue à l'égard de plusieurs questions. Les morts peuvent-ils subir un « préjudice » ? En ce qui a trait à l'utilisation médicale du corps de patients qui viennent de mourir, quelles pratiques sont acceptables, lesquelles sont odieuses ? La vente de tissus humains porte-t-elle atteinte, en soi, à la dignité humaine ? Le fait de considérer le corps comme un bien est-il incompatible avec notre vision morale de l'être humain ? Telle politique de prélèvement des tissus est-elle plus susceptible que telle autre de susciter des attitudes et des pratiques nuisibles ?

Troisièmement, malgré les différends philosophiques et la difficulté de mesurer, de comparer et de classer les valeurs en cause, la bioéthique s'avère utile lorsqu'il s'agit de déterminer en gros quelles sont les politiques envisageables. Supposons, par exemple, que la politique du « don de la vie » soit jugée préférable, et que les autorités soient incapables de trancher le débat philosophique concernant le rôle des émotions dans la morale, qui oppose les tenants de l'altruisme et les partisans du prélèvement discrétionnaire. Elles pourraient alors se demander si la politique de l'altruisme, privilégiée jusqu'ici, a équitablement et suffisamment été mise à l'épreuve. Cette solution ayant été favorisée au départ, on pourrait à la suite de cette évaluation y apporter des modifications, voire l'abandonner, dans le cas où elle s'avérerait inefficace ou trop coûteuse.

Cette méthode est également applicable dans le cas de la vente de tissus humains. Indépendamment du débat sur les objections d'ordre formaliste ou fondées sur les conséquences, on pourrait conclure simplement qu'elle n'est pas la solution préférable

du point de vue de l'éthique, surtout s'il est possible de démontrer que les tissus nécessaires peuvent être obtenus par des moyens plus satisfaisants sur ce plan. Dans le cas où il ne s'avérerait pas indiqué d'opter, quant à la vente de tissus, pour une interdiction ou une liberté totales, l'établissement de distinctions pragmatiques entre les ventes les plus condamnables au regard de l'éthique, et celles qui le sont le moins, pourrait indiquer aux autorités des solutions viables et moralement acceptables. Bien entendu, cela implique aussi des choix d'ordre moral et, partant, la politique ainsi retenue touchera et remuera les valeurs essentielles qui paraissent si intimement liées à l'éthique du prélèvement.

CHAPITRE TROIS

La situation juridique actuelle : droits, obligations, ambiguïtés

Le droit fournit certaines réponses aux questions suscitées par l'accroissement de l'utilisation et du stockage à des fins médicales des tissus et des substances du corps humain. Dans le présent chapitre, nous examinerons les principes constitutionnels, les règles de la common law ainsi que les textes législatifs (de droit pénal comme de droit civil) liés aux grands problèmes définis au chapitre premier (consentement, droit de propriété, vente). Comme, bien souvent, le droit s'intéresse aux droits et aux obligations de « parties adverses », cette étude est surtout axée sur l'importance relative accordée par le législateur aux intérêts des donneurs et de leurs familles, des receveurs, des professionnels de la santé et de la collectivité ou de l'État.

I. Common law et droit civil

Quels sont les droits et les obligations établis par la common law et le droit civil en matière de prélèvements de substances et de tissus corporels sur des personnes vivantes ou mortes ? Les éléments de réponse obtenus ne sont pas importants uniquement d'un point de vue historique. Ils éclairent, et déterminent parfois, les relations juridiques en ce qui concerne le stockage et la vente de tissus, le consentement aux autopsies et d'autres questions semblables où la loi est parfois ambiguë ou silencieuse.

A. Intégrité corporelle et consentement

La Cour suprême du Canada a récemment déclaré que l'intégrité corporelle est une valeur à laquelle la société attache un très grand prix, une valeur qui implique certains droits fondamentaux[362]. Il n'est donc pas surprenant que la loi donne concrètement effet à cette valeur. Le simple fait de toucher une personne sans son consentement peut engager la responsabilité civile, voire pénale[363]. Par conséquent, le principe du consentement

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362. *E. (M^me^) c. Eve*, [1986] 2 R.C.S. 388, 406, 434.

363. Une poursuite en responsabilité civile serait normalement fondée sur l'infraction de voies de fait. Voir, par exemple, *Malette c. Shulman* (1990), 67 D.L.R. (4^e^) 321 (C.A. Ont.). Pour des précisions sur l'infraction de voies de fait, voir *infra*, section II.

éclairé[364], et celui de l'inviolabilité de la personne humaine[365] consacré au Code civil, subordonnent certains actes des professionnels de la santé au consentement préalable du patient[366].

L'origine de ces principes est ancienne. En fait, le droit reconnaît depuis des siècles qu'il incombe au médecin d'obtenir le consentement de son patient avant d'entreprendre un traitement[367]. D'abord appliqué au moyen de poursuites fondées sur la notion de *trespass*[368], puis celle de *battery*, ce principe s'exprime aujourd'hui par l'obligation, pour le médecin, de divulguer le but et les risques réels de l'intervention envisagée, ainsi que les différentes options offertes, de sorte que le patient puisse donner un consentement volontaire et éclairé[369]. On reconnaît généralement au patient le droit de refuser un traitement[370]. La règle du consentement obligatoire, par ailleurs, n'est pas absolue. En effet, elle ne s'applique pas dans les cas d'urgence[371], lorsque le patient a renoncé à son droit ou dans les rares cas où il est de toute évidence contraire à son intérêt de lui communiquer certains renseignements médicaux ayant trait à son cas[372].

La règle du consentement vise à donner effet au principe de l'autonomie de la personne, à préserver l'intégrité physique du patient et à promouvoir la compréhension entre ce dernier et son médecin, qui peut avoir des effets bénéfiques dans le cadre du traitement. Sur le plan conceptuel, on se trouve ainsi à considérer la relation entre le médecin et son patient comme l'occasion d'échanger des renseignements en toute franchise[373], comme une association favorisant la prise de décisions rationnelles. On suppose que le patient sera

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364. Voir Ellen I. PICARD, *Legal Liability of Doctors and Hospitals in Canada*, 2e éd., Toronto, Carswell, 1984, ch. III, p. 41.

365. Voir les art. 19, 19.1, 984, 1053 du *Code civil du Bas Canada* (C.c.) ; *Chouinard* c. *Landry*, [1987] R.J.Q. 1954 (C.A.). Voir en général, François HELEINE, « Le dogme de l'intangibilité du corps humain et ses atteintes normalisées dans le droit des obligations du Québec contemporain » (1976), 36 *R. du B.* 2. On trouvera des observations plus approfondies sur les dispositions du Code civil concernant le don de tissus humains dans la section III, ci-après.

366. Au sujet de la protection de l'intégrité corporelle en droit pénal, voir la discussion relative aux voies de fait dans la section II, ci-après.

367. Voir *Slater* c. *Baker* (1767), 95 E.R. 860 (K.B.).

368. Voir *Mulloy* c. *Hop Sang*, [1935] 1 W.W.R. 714 (C.A. Alb.).

369. Voir *Reibl* c. *Hughes*, [1980] 2 R.C.S. 880. Voir également Robert P. KOURI, « L'influence de la Cour suprême sur l'obligation de renseigner en droit médical québécois » (1984), 44 *R. du B.* 851. Voir en général, Margaret A. SOMERVILLE, *Le consentement à l'acte médical*, document d'étude rédigé pour la CRD, Ottawa, Approvisionnements et Services Canada, 1980.

370. *Couture-Jacquet* c. *The Montreal Children's Hospital*, [1986] R.J.Q. 1221 (C.A.) ; *Malette* c. *Shulman*, précité, note 363. Voir également, CRD, *Le traitement médical et le droit criminel*, Document de travail n° 26, Ottawa, Approvisionnements et Services Canada, 1980.

371. *Murray* c. *McMurchy*, [1949] 2 D.L.R. 442 (C.S. C.-B.).

372. Voir, en général, Paul S. APPELBAUM, Charles W. LIDZ et Alan MEISEL, *Informed Consent: Legal Theory and Clinical Practice*, New York, Oxford University Press, 1987, ch. IV, p. 66.

373. Voir, en général, Note, « Restructuring Informed Consent: Legal Theory for the Doctor-Patient Relationship » (1970), 79 *Yale L.J.* 1533. Voir également PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVORIAL RESEARCH [ci-après PRESIDENT'S COMMISSION], *Making Health Care Decisions: A Report on the Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship, vol. 1*, Washington (D.C.), la Commission, 1982, pp. 41-50.

en mesure, malgré ses craintes, de comprendre les options offertes, guidés par les conseils judicieux du médecin ; qu'ils sera davantage susceptible de collaborer et de participer plus activement au processus thérapeutique. On présume en outre que le médecin tire également profit du partage de la prise de décision[374] : lorsque le patient comprend mieux la situation et s'intéresse activement au traitement, les chances de guérison sont meilleures, pense-t-on. Vu sous cet angle, le droit est à la fois fonctionnel et humanitaire. D'une part, [TRADUCTION] « il contribue à la réalisation d'un bien-être subjectif, et [d'autre part] il est revêtu d'une valeur intrinsèque en tant qu'élément de la dignité et de l'intégrité de la personne[375] ».

Les règles relatives au consentement s'appliquent à toutes les techniques médicales et chirurgicales liées au don et à la transplantation de tissus humains, et notamment aux thérapies nouvelles ou expérimentales[376]. Si les idéaux qui sous-tendent le modèle du choix médical éclairé ne sont pas faciles à traduire dans la pratique[377], la théorie elle-même se heurte à des difficultés en ce qui a trait aux mineurs[378] et aux personnes atteintes de déficience mentale, lorsque ces personnes sont incapables d'exercer un choix[379]. Dans un tel cas, les parents ou le tuteur du mineur se voient parfois conférer le pouvoir de consentir à l'acte médical. En vertu du *Code civil du Québec*, par exemple, le mineur doué de discernement peut, avec le consentement du titulaire de l'autorité parentale et l'autorisation du tribunal, faire un don de tissus si le risque couru n'est pas hors de proportion avec le bienfait qu'on peut en espérer[380].

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374. Voir J. KATZ et A.M. CAPRON, *op. cit.*, note 281, pp. 79, 87.

375. PRESIDENT'S COMMISSION, *Deciding to Forego Life-Sustaining Treatment: A Report on the Ethical, Medical, and Legal Issues in Treatment Decisions*, Washington (D.C.), la Commission, 1983, p. 26. Voir également *Making Health Care Decisions*, *op. cit.*, note 373, pp. 41-50.

376. Comparer *Halushka* c. *University of Saskatchewan* (1965), 52 W.W.R. 608 (C.A. Sask.) et *Karp* c. *Cooley*, 493 F. 2d 408 (5th Cir. 1974) (consentement à l'implantation d'un cœur mécanique expérimental). Voir également *Weiss* c. *Solomon*, [1989] R.J.Q. 731 (C.S.). Voir, en général, Document de travail n° 61, *op. cit.*, note 295.

377. Voir William A. SILVERMAN, « The Myth of Informed Consent: in Daily Practice and in Clinical Trials » (1989), 15:1 *J. Med. Ethics* 6 ; J. KATZ, *op. cit.*, note 68, p. 84.

378. Voir *Saskatchewan (Minister of Social Services)* c. *P. (F.)* (1990), 69 D.L.R. (4e) 134 (C.P. Sask.) (pouvoir des parents de refuser qu'une transplantation du foie soit pratiquée sur leur bébé. Voir W.F. BOWKER, « Minors and Mental Incompetents: Consent to Experimentation, Gifts of Tissue and Sterilization » (1980-1981), 26 *R.D. McGill* 951. On trouvera des observations ayant trait à l'éthique au chapitre II. Pour des observations analogues ayant trait au droit pénal, voir la section II, ci-après.

379. Voir Paul S. APPELBAUM et Thomas GRISSO, « Assessing Patients' Capacities to Consent to Treatment » (1988), 319:25 *N. Engl. J. Med.* 1635. Voir également *Re Spring*, 405 N.E. 2d 115 (Mass. 1980) (le tribunal a autorisé l'interruption d'un traitement de dialyse rénale dans le cas d'un homme atteint de déficience mentale).

380. C.c., art. 20. Voir *Cayouette et Mathieu*, [1987] R.J.Q. 2230 (C.S.) (le tribunal a autorisé un enfant de 5 ans à faire don de sa moelle osseuse à son frère atteint de leucémie, en se fondant sur l'art. 20 du C.c. Certaines modifications à cette disposition ont été proposées. Voir Robert P. KOURI, « Le consentement aux soins médicaux à la lumière du projet de loi 20 » (1987), 18 *R.D.U.S.* 27, et *Code civil du Québec*, projet de loi 125, 1re session, 34e législature (Québec), (1990) lequel a été sanctionné pendant la préparation du présent document ; voir L.Q. 1991, ch. 64.

Toutefois, le pouvoir des parents ou du tribunal d'autoriser certaines interventions médicales liées aux greffes et aux transplantations n'est pas illimité dans le cas du mineur non doué de discernement. Les risques courus par le donneur, les éventuels bienfaits psychologiques du don pour lui, les bienfaits espérés pour le receveur, tout cela doit être soupesé avec le plus grand soin lorsqu'il s'agit de justifier une intervention irréversible qui porte gravement atteinte à l'intégrité corporelle, comme le don d'un rein entre frères ou sœurs mineurs :

> Le pouvoir discrétionnaire doit être exercé à l'avantage de cette personne mais pas pour celui des autres. Il s'agit également d'un pouvoir discrétionnaire qui doit en tout temps être exercé avec une grande prudence dont il faut redoubler selon que la gravité d'une affaire augmente. Il faut évaluer les justifications marginales par rapport à ce qui, dans chaque cas, constitue une grave atteinte à l'intégrité physique et mentale de la personne[381].

B. Droit de propriété et droit de possession

Suivant une maxime juridique datant du XVII[e] siècle, le corps humain n'est pas susceptible d'appropriation. Y a-t-il lieu de renoncer à ce principe en cette fin du XX[e] siècle, à l'ère des greffes d'organes et de la biotechnologie ? Chose certaine, sa pertinence a été remise en question par la médecine moderne et l'évolution du droit. De plus en plus, le corps humains et ses éléments constitutifs — organes, tissus, liquides — font l'objet de dons et de prélèvements, sont stockés pendant des années à toutes sortes de fins thérapeutiques. Certaines substances corporelles sont commercialisées. Si notre corps et nos organes ne nous appartiennent pas, que nous est-il permis d'en faire ?

Notre analyse semble indiquer que la common law reconnaît un « droit de propriété » très limité à l'égard du corps humain, à des fins particulières. D'une part, elle réitère la règle traditionnelle, vu les conséquences déplorables, du point de vue de l'éthique, d'une commercialisation des parties du corps. D'autre part, elle reconnaît à l'exécuteur testamentaire ou à la famille un droit de possession sur la dépouille des donneurs potentiels — il s'agit de protéger des sentiments familiaux, moraux et religieux. Dans le cas des donneurs vivants, la common law répugne aussi à reconnaître l'existence d'un droit de propriété sur le corps humain. Elle tend à se fonder sur des principes importants, mais parfois limités, ayant trait au consentement éclairé et aux dommages-intérêts accordés pour troubles émotifs, pour réprimer l'utilisation de tissus extra-corporels sans le consentement de l'intéressé. Vu les nouveaux impératifs biomédicaux et biotechnologiques, il paraît de plus en plus essentiel de se pencher sur le concept juridique et la définition de la propriété. Les progrès de la science remettent en cause l'ambivalence juridique traditionnelle de la règle qui interdit de considérer le corps et ses éléments comme des « biens ». Ils invitent la société à repenser les choix qui lui sont offerts pour l'établissement, en cette ère nouvelle, d'une politique de prélèvement des tissus humains qui continue à promouvoir la dignité humaine, le respect de la vie privée et l'intégrité du corps humain.

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381. *Eve*, précité, note 362, 427, 434 (le pouvoir du tribunal d'autoriser la stérilisation non thérapeutique d'un adulte atteint de déficience mentale est restreint). Voir également Bernard M. DICKENS, « Case Comment: *Eve* v. *E.* » (1987), *Can. Fam. L.Q.* 103.

(1) Donneurs décédés

En common law comme en droit civil, on a toujours estimé que le cadavre humain n'est pas susceptible d'appropriation[382]. Son caractère sacré tire évidemment son origine de coutumes religieuses. Le *Code civil du Bas Canada*, dans les dispositions relatives aux questions funéraires, parle des restes des morts comme étant des « choses sacrées de leur nature[383] ». De la même manière, la règle de la common law tire son origine de la jurisprudence anglaise des XVI^e^ et XVII^e^ siècles et des observations d'Edward Coke, selon lesquelles l'inhumation relevait de la compétence de l'Église, les cadavres enterrés n'appartenant du reste à personne *(nullis in bonis)*[384]. Les tribunaux d'Angleterre étant peu à peu saisis de causes confiées auparavant aux tribunaux ecclésiastiques, ils ont repris dans la jurisprudence anglaise concernant les cadavres le principe énoncé par Coke[385].

Malgré la règle traditionnelle, la common law et le droit civil reconnaissaient un certain nombre d'intérêts qui jouissent encore de nos jours d'une protection juridique. On peut penser, par exemple, au droit de chacun à une inhumation décente[386], établi depuis longtemps dans les deux systèmes, même si la common law ne conférait pas d'une manière absolue le droit de déterminer, par dispositions testamentaires, le sort réservé à sa dépouille[387]. Dans le but de garantir le respect du droit à une inhumation décente, la loi précisait qu'il incombe à l'exécuteur testamentaire ou à la famille d'inhumer le défunt, en leur conférant à cette fin le droit à la possession du cadavre :

> [TRADUCTION]
> Au Canada, c'est à l'exécuteur testamentaire que l'inhumation du cadavre incombe. Si le testament ne désigne aucun exécuteur, le droit à la possession du corps aux fins d'inhumation est conféré au conjoint survivant [. . .] S'il n'y a pas de conjoint survivant, il est conféré au plus proche parent[388].

Ce droit à la possession est parfois qualifié de droit de « quasi-propriété »[389]. Il

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382. On trouvera des observations sur la perspective du droit civil dans R. DIERKENS, *Les droits sur le corps et le cadavre de l'homme*, Paris, Masson, 1966, pp. 157-158.

383. Article 2217 C.c.

384. Voir Edward COKE, *The Third Part of the Institutes of the Laws of England*, 5^e^ éd., Londres, A. Crooke, 1671, p. 103 ; l'auteur s'appuie notamment sur l'affaire *Haynes* (1614), 77 E.R. 1389 (vol de vêtements funéraires, et non de la dépouille).

385. Voir Paul MATTHEWS, « Whose Body? People as Property » (1983), 35 *Current Legal Problems* 193, 197-204, 240, où est analysée l'affaire *Williams* c. *Williams* (1882), 20 Ch. D. 659, 665.

386. *Re Atkins*, [1989] 1 All E.R. 14, 16 ; *Hunter* c. *Hunter*, [1930] 4 D.L.R. 255 (C.S. Ont.) ; *Lambert* c. *Dumais*, [1942] B.R. 561. Le lecteur qui voudrait consulter la jurisprudence américaine pourra se reporter aux décisions signalées dans Annotation, « Validity and Effect of Testamentary Direction as to Disposition of Testator's Body », 7 A.L.R. 3d 747.

387. *Ibid.*

388. Lorne Elkin ROZOVSKY, « Death, Dead Bodies and the Law » (1970), 47:7 *Can. Hosp.* 52. Voir également *Lambert*, précité, note 386 et *Hunter*, précité, note 386.

389. Voir *Edmonds* c. *Armstrong Funeral Home*, [1931] 1 D.L.R. 676 (C.S. Alb.) (le conjoint peut intenter une poursuite pour préjudice moral en raison d'une autopsie non autorisée) ; *Philipps* c. *The Montreal General Hospital*, (1908) 33 C.S. 483, 489 (un conjoint peut intenter une poursuite pour préjudice moral en raison d'une autopsie non autorisée). Au sujet de la situation aux États-Unis, voir *Prosser and Keeton on the Law of Torts*, 5^e^ éd., St. Paul (Minn.), West Publishing, 1984, p. 63 et *Restatement of the Law, Second of Torts*, 2^e^ éd., rev. et augm., vol. 4, St. Paul (Minn.), American Law Institute Pub., 1979.

donne au conjoint ou au plus proche parent la possibilité d'intenter une poursuite en dommages-intérêts lorsqu'il a été porté atteinte à sa tranquillité mentale ou émotive (*wrongful infliction of emotional distress*, en common law)[390]. Les atteintes au droit de possession peuvent prendre plusieurs formes : négligence dans la manipulation ou le transport de cadavres[391], rétention d'un cadavre jusqu'au paiement des frais funéraires[392], coupe des cheveux du défunt par le salon funéraire sans autorisation[393], rétention du cadavre pour une période de temps déraisonnable en vue de déterminer la possibilité d'un don d'organes[394], mutilation du cadavre lors d'une autopsie non autorisée[395].

Il semble du reste ressortir de la jurisprudence canadienne et étrangère relative aux autopsies faites sans autorisation que le droit à la possession conféré au proche parent pour l'inhumation du cadavre pourrait comporter le droit de recevoir le corps exempt de mutilation. La question se pose parfois à propos des autopsies pratiquées à l'hôpital, qui diffèrent des autopsies ordonnées par un médecin légiste ou un coroner en cas de mort soudaine, inattendue, non naturelle ou suspecte[396]. Les autopsies médico-légales sont régies par des lois provinciales[397]. Comme le coroner exerce des fonction quasi judiciaires, il peut être autorisé à requérir des autopsies sans le consentement de la famille du défunt lorsque l'intérêt public et l'administration de la justice exigent la détermination des causes du décès[398]. Les autres autopsies nécessitent en général le consentement préalable du défunt ou celui de ses proches parents[399]. Dans la mesure où celles qui sont pratiquées à l'hôpital sont assujetties aux textes provinciaux autorisant la famille à consentir au prélèvement de tissus en vue de greffes ou de transplantations, ou encore pour la formation ou la recherche médicales, elles peuvent elles aussi être visées par les dispositions qui, dans ces textes, concernent le consentement et la responsabilité[400].

D'après les principes de la commoon law, il y a lieu de croire que le conjoint du défunt ou son proche parent peut intenter une action pour souffrances morales si l'autopsie

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390. Voir S.M. WADDAMS, *The Law of Damages*, Toronto, Canada Law Book, 1983, p. 452.

391. *Miner* c. *Canadian Pacific R.W. Co.* (1911), 18 W.L.R. 476 (C.S. Alb.).

392. Voir *R.* c. *Fox* (1841), 2 Q.B. 242 et *Hunter*, précité, note 386.

393. *Mensinger* c. *O'Hara*, 189 Ill. App. 48 (1914).

394. *Strachan* c. *John F. Kennedy Memorial Hospital*, 538 A. 2d 346 (N.J. 1988).

395. *Edmonds*, précité, note 389.

396. Voir en général Christopher GRANGER, *Canadian Coroner Law*, Toronto, Carswell, 1984.

397. Voir par exemple, *Loi sur la recherche des causes et des circonstances des décès*, L.R.Q., ch. R-0.2. Voir également C. GRANGER, *op. cit.*, note 396.

398. Voir *Davidson* c. *Garrett* (1899), 5 C.C.C. 200 (H.C. Ont.). Voir également *Religieuses Hospitalières de l'Hôtel-Dieu de Montréal* c. *Brouillette* (1943), B.R. 441. Pour de la jurisprudence portant sur la question de savoir dans quels cas des textes régissant les autopsies peuvent porter atteinte à la liberté de croyance religieuse constitutionnellement garantie, voir la section IV.C, ci-après.

399. Voir *Ducharme* c. *Hôpital Notre-Dame* (1933), 71 C.S. 377 ; *Edmonds*, précité, note 389 et *Philipps*, précité, note 389. Voir également l'art. 20 C.c.

400. Voir L.E. ROZOVSKY, *loc. cit.*, note 388. Voir également la section III, ci-après. Pour ce qui est des règles établies dans d'autres pays au sujet du consentement en matière d'autopsie, voir Einar SVENDSEN et Rolla B. HILL, « Autopsy Legislation and Practice in Various Countries » (1987), 111 *Arch. Pathol. Lab. Med.* 846.

déborde les cadres habituels ou va au-delà de ce qui avait été autorisé[401]. La jurisprudence canadienne publiée ne semble encore comporter aucune décision sur la question. À l'étranger, toutefois, on a invoqué le principe du droit à la possession reconnu en droit canadien pour accueillir des actions portant sur la rétention inutile de parties du corps à la suite d'une autopsie autorisée. Ainsi, un tribunal américain a pu conclure que le prélèvement injustifié, la destruction ou la rétention inutile d'organes lors d'une autopsie autorisée par la famille avaient causé au conjoint ou au proche parent un préjudice (choc, souffrances morales) susceptible de réparation[402]. La rétention par un coroner des organes excisés durant une autopsie médico-légale a même donné lieu à l'attribution de dommages-intérêts, l'autopsie ayant débordé les limites autorisées par la loi[403]. Une affaire américaine récente montre que le droit à la possession peut également protéger les croyances religieuses. En condamnant l'hôpital à des dommages-intérêts pour avoir retenu et incinéré des organes sans autorisation, le tribunal a déclaré :

> [TRADUCTION]
> La plupart des religions du monde enseignent que les restes humains doivent être traités avec dignité et respect. Le judaïsme croit au principe selon lequel le corps et l'âme sont sacrés parce qu'ils sont l'œuvre de Dieu et que, partant, ils méritent le respect. [...]
>
> Le droit applicable exige donc que ceux qui s'occupent du corps le fassent en ayant égard aux sentiments et aux croyances des proches parents. Ces derniers, autrement dit, ont droit à ce que le cadavre soit traité avec respect et, dans le cas de ceux qui partagent les croyances des demandeurs, il s'agit d'un droit apparenté à celui protégé par le premier amendement [protection constitutionnelle de la liberté de religion][404].

Les causes relatives à des autopsies non autorisées portent à croire que la loi protège l'intégrité du corps du défunt dans la mesure où elle est reliée aux intérêts affectifs et religieux du conjoint ou des proches parents.

Toutefois, le droit de la famille à la possession du cadavre n'est pas absolu. Il est en effet fonction de l'obligation d'inhumer, de sorte que le fait de traiter un cadavre d'une manière non conforme aux rites funéraires pourrait donner lieu à des poursuites[405]. De plus, tout texte législatif répondant à l'intérêt de l'État peut prévaloir sur le droit à la

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401. Voir Susan SCHMIDT, « Consent for Autopsies » (1983), 250:9 *JAMA* 1161, 1163. Comparer *Edmonds*, précité, note 389 et *Hendriksen* c. *Roosevelt Hospital*, 297 F. Supp. 1142 (S.D.N.Y. 1969) (des poursuites sont envisageables lorsque le prélèvement d'organes internes outrepasse la portée du consentement à l'autopsie). On trouvera des explications sur le droit écossais en la matière dans *Hughes* c. *Robertson* (1913), Sess. Cas. 394 (Ct. Sess. Scot.). Voir également *Hill* c. *Travelers' Insurance Co.*, 294 S.W. 1097 (Tenn. 1927) (le fait de conserver sans autorisation, après une autopsie, les organes vitaux du conjoint décédé, peut constituer une cause d'action).

402. Voir par exemple, *Palmquist* c. *Standard Accident Insurance*, 3 F. Supp. 358 (D.C. Cal. 1933) (dommages-intérêts pour souffrances morales causées par le refus du médecin de remettre les organes prélevés durant l'autopsie). Voir en général les causes citées dans James O. PEARSON, « Liability for Wrongful Autopsy », 18 A.L.R. 4th 858.

403. Voir *Hassard* c. *Lehane*, 128 N.Y. 161 (1911) ; *Kirker* c. *Orange County*, 519 So. 2d 682 (Fla. App. 1988). Comparer *Arnaud* c. *Odom*, *infra*, note 872.

404. *Kohn* c. *United States*, 591 F. Supp. 568, 572-573 (1984). Comparer *Disinterment of Body of Jarvis*, 53 N.W. 2d 24, 28 (Iowa 1953) (le consentement à une autopsie implique le consentement à la rétention des morceaux de tissus prélevés conformément aux pratiques généralement acceptées de la pathologie).

405. Voir P. MATTHEWS, *loc. cit.*, note 385.

possession conféré au conjoint ou au proche parent. Nous venons de parler des autopsies médico-légales et de leur rôle en matière de justice pénale. Les responsabilités de l'État au regard de la santé publique, qui suppose l'embaumement et, dans certains cas, la destruction des cadavres, peuvent également l'emporter sur le droit en question[406]. En outre, le souci de sauver des vies (auquel la société attache la plus grande valeur) peut justifier le prélèvement d'organes sur un cadavre dans des situations d'urgence, ou lorsqu'il n'est pas possible de communiquer avec un membre de la famille[407].

Il faut donc conclure qu'on reconnaît depuis longtemps à la famille des donneurs potentiels un droit, juridiquement consacré et ancré dans la coutume, à la possession du cadavre. Ce droit, lorsqu'il n'est pas modifié par des textes législatifs, impose d'une manière générale aux hôpitaux et aux médecins l'obligation de respecter les intérêts de la famille du patient décédé considéré comme un donneur d'organes potentiel. Force est d'admettre qu'il y a là une ambivalence juridique manifeste. Au sens strict, la « possession » implique la pleine et légitime maîtrise sur la chose. D'une part, le cadavre n'est pas susceptible d'appropriation suivant la règle traditionnelle ; d'autre part, le droit reconnaît l'existence, à son égard, d'intérêts relevant de la possession ou de la propriété.

L'ambivalence découle en partie de l'opposition entre deux grandes conceptions de la propriété. L'une est axée sur notre rapport aux choses ; l'autre, sur notre rapport à autrui au sujet des choses :

> [TRADUCTION]
> Dans les sociétés occidentales, le droit de propriété n'est plus considéré comme absolu, si tant est qu'il l'ait déjà été. [...]
>
> Le mot « propriété » a plusieurs sens. Il peut viser les biens matériels d'une personne, ses biens immobiliers ou l'ensemble de ses avoirs composé de biens matériels et de droits incorporels (créances, fonds en fiducie, actions, brevets, etc.). La propriété peut donc viser des objets matériels et des droits. Elle peut en outre viser les relations juridiques entre des personnes, ces biens matériels et ces droits [...].
>
> *Par conséquent, le droit s'intéresse au contenu du droit de propriété, à savoir les droits, privilèges, pouvoirs et immunités qui le constituent, et non à la chose ou au droit concrets eux-mêmes.* Les objets ou les droits concrets, après tout, peuvent être très variés alors que les pouvoirs ou les droits sont bien déterminés. [...] On pourrait, à partir de cette liste, en dresser une autre qui établirait les pouvoirs, les droits, les privilèges et les immunités spécifiques eu égard à la propriété. *Par conséquent, la propriété n'est pas simplement un droit, mais plutôt un ensemble de droits et de pouvoirs*[408].

La distinction s'avère subtile mais importante. Le fait de définir la propriété en termes de droits et d'obligations de personnes au sujet de choses permet d'atténuer l'apparente ambivalence du droit. La distinction permet également à la société de classer et de définir,

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406. Voir Frank P. GRAD, *Public Health Law Manual*, New York, American Public Health Association, 1970.

407. Voir les précisions sur la législation relative aux cadavres non réclamés et l'art. 22 du *Code civil du Québec* (autorisation de prélever les organes sans le consentement des proches) figurant dans la section III, ci-après.

408. A.H. OOSTERHOFF et W.B. RAYNER, *Anger and Honsberger Law of Real Property*, vol. 1, 2e éd., Aurora (Ont.), Canada Law Book, 1985, art. 102, pp. 5-6 [mis en italiques par nos soins].

largement ou strictement, des droits, des devoirs et des pouvoirs particuliers. Par exemple, si les tissus humains ne doivent pas, en général, être considérés comme des objets de commerce ni des biens susceptibles de transmission par succession, faut-il en conclure que le droit ne devrait reconnaître aucun droit de propriété sur les parties du corps humains et les substances corporelles ? La réponse dépend en partie de la façon dont on conçoit et on définit la propriété, et dans quel but on le fait. L'idée que le corps puisse être considéré comme un bien évoquera des images d'esclavage qui répugnent à la morale — des hommes propriétaires d'autres hommes. Toutefois, comme l'indiquent les règles de droit touchant les cadavres, le droit de possession conféré aux proches parents relativement à la dépouille ne comporte pas le droit de vendre celle-ci — tout comme le droit de possession dont jouit le locataire d'un appartement ne comporte normalement pas le droit de vendre celui-ci. Si les notions de propriété et de commerce sont liées, le droit de vente n'a pas nécessairement à être rattaché à des droits de propriété conférés par la loi[409].

La règle suivant laquelle le cadavre n'est pas susceptible d'appropriation présente peut-être d'autres limites dans la société d'aujourd'hui. La société, tout comme l'utilisation médicale du corps humain, a énormément évolué au cours des trois siècles qui se sont écoulés depuis son instauration. À l'époque, la plupart des cadavres étaient inhumés dans les lieux consacrés d'un cimetière[410]. La règle en question n'a-t-elle pas perdu dans une certaine mesure sa logique et son utilité, maintenant que l'on préserve des cadavres entiers ainsi que des organes, des substances et des tissus corporels, soit pour l'enseignement de l'anatomie, soit pour alimenter des banques de tissus humains dans lesquelles on puise à des fins thérapeutiques ou en vue d'effectuer des greffes et des transplantations ?

(2) Donneurs vivants

La règle est-elle applicable aux vivants ? Au Canada, il ne semble y avoir aucune cause où cette question ait été spécifiquement soulevée. Aux États-Unis, les tribunaux ont eu tendance, dans certaines décisions, à l'appliquer dans le cadre de différends portant sur des donneurs vivants, bien que des jugements récents aillent en sens contraire. La notion de propriété a été l'objet de litiges dans quatre grands domaines en particulier : élimination, sans le consentement d'une personne, de tissus prélevés sur elle ; droit de disposer de substances corporelles préalablement déposées ; utilisation de substances ou de tissus corporels sans le consentement de l'intéressé ; valeur commerciale des substances et des tissus corporels.

a) Élimination de tissus sans le consentement de l'intéressé

Aux États-Unis, certaines actions ont été intentées par suite de l'élimination de tissus humains sans le consentement du donneur ou du déposant. Dans deux poursuites, l'une

409. Voir également *supra*, ch. II, section IV.B.

410. Voir, *supra*, le texte accompagnant la note 384.

portant sur la perte d'un tissu oculaire soumis à des examens visant au dépistage d'un cancer, et l'autre sur l'élimination de substances reproductives sans le consentement de l'intéressé, les tribunaux ont évité de fonder leur décision sur la notion de propriété. Ils ont plutôt choisi d'analyser ces affaires du point de vue du choc émotif ou des souffrances morales subies par le patient[411]. Cela porte à croire que certains tribunaux américains ont étendu aux parties du corps des personnes vivantes la règle voulant que le cadavre ne soit pas susceptible d'appropriation.

Certains auteurs ont critiqué cette tendance[412]. Il faut signaler du reste qu'à certains endroits, la possibilité d'intenter une action pour choc émotif a été limitée[413]. On fait valoir que même lorsqu'il est possible d'accorder des dommages-intérêts pour de telles souffrances, cela est de peu d'utilité pour les personnes qui souhaitent obtenir la restitution de substances ou de tissus humains précieux[414]. Les règles ressortissant à la propriété, soutient-on, conviendraient mieux lorsqu'il s'agit de protéger l'autonomie et la personne, et permettraient en outre de préciser, sur le plan juridique, les droits et les obligations rattachés à l'utilisation de tissus humains dans des circonstances particulières. Lorsqu'un établissement, par exemple, détruit, sans le consentement de l'intéressé, un tissu humain précieux, et que le législateur a limité l'attribution de dommages moraux, les règles de la common law relatives à la destruction ou à la détérioration des objets en la possession légitime d'une personne pourraient s'avérer utiles pour la détermination des droits, des obligations et des motifs justifiant la restitution[415].

b) Droit à la restitution de substances corporelles préalablement déposées

Les problèmes juridiques que soulève l'utilisation de tissus humains se sont posés de la manière la plus aiguë dans certaines causes récentes concernant les substances

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411. Voir *Del Zio* c. *Manhattan's Columbia Presbyterian Medical Center* (14 novembre 1978), New York 74-3558 (S.D.) (substance reproductive), décrit dans L.B. ANDREWS, *loc. cit.*, note 344, 29 ; *Mokry* c. *University of Texas Health Science Center*, 529 S.W. 2d 802 (Tex. App. 1975) (tissu oculaire). Comparer *Browning* c. *Norton-Children's Hospital*, 504 S.W. 2d 713 (Ky App. 1974) (amputation d'une jambe).

412. Voir par exemple, P.D.G. SKEGG, « Human Corpses, Medical Specimens and the Law of Property » (1975), 4 *Anglo-Am. L. Rev.* 412, 424, n. 39 ([TRADUCTION] « La raison qui explique le refus traditionnel des tribunaux de common law de reconnaître un droit de propriété sur les cadavres n'est pas applicable aux parties prélevées sur un donneur vivant. Le droit de propriété devrait d'abord être reconnu à la personne sur laquelle la partie a été prélevée. Toutefois, on supposera dans bien des cas qu'elle a renoncé à son droit ou l'a transféré. »).

413. Voir *McNeil* c. *Forest Lawn Memorial Services* (1976), 72 D.L.R. (3e) 556 (C.S. C.-B.) (dommages-intérêts accordés uniquement dans les cas de manquement volontaire à ses obligations) ; John G. FLEMING, *The Law of Torts*, 6e éd., Sydney, Law Book, 1983, pp. 30-31, 146-147. Voir cependant *Restatement of the Law*, *op. cit.*, note 389 ; *St. Elizabeth Hospital* c. *Garrard*, 730 S.W. 2d 649 (Tex. 1987) (dommages-intérêts pour souffrances morales accordés aux parents d'un enfant mort-né, parce qu'on n'a pas tenu compte de leurs désirs concernant les mesures à prendre à l'égard du cadavre).

414. Voir Bernard M. DICKENS, « The Control of Living Body Materials » (1977), 27 *U.T.L.J.* 142, 147-149.

415. *Ibid.* Voir également *York* c. *Jones Institute*, 717 F. Supp. 421 (E.D. VA 1989) (application des principes relatifs au dépôt et à la détention illicite).

reproductives. Aucune décision n'a été publiée au Canada sur la question, mais un couple américain a réussi récemment à se faire reconnaître par les tribunaux le droit de disposer de son embryon congelé et de le transporter d'une clinique de fertilité de la côte est à une clinique de la côte ouest[416]. En France, l'épouse d'un homme qui, obligé de subir des traitements anticancéreux risquant de le rendre stérile, avait fait congeler son sperme, a soutenu après le décès de son mari qu'elle avait le droit de se faire remettre la semence ainsi déposée[417]. Le tribunal a expressément rejeté l'argument selon lequel le sperme congelé était une chose susceptible d'appropriation, au motif que les substances reproductives humaines ne sont pas transmissibles par succession et ne peuvent faire l'objet d'un commerce[418]. Il a tout de même conclu que la banque de sperme devait remettre le sperme congelé à l'épouse, en raison d'une entente à ce sujet entre le déposant et l'établissement[419]. Cette décision donne à penser que la conclusion d'ententes entre les banques de tissus et les déposants, exprimées dans des formulaires bien rédigés relatifs au consentement éclairé, pourrait contribuer à réduire le nombre de différends touchant la disposition des tissus déposés, à défaut de mesures législatives ou de normes professionnelles régissant suffisamment la question.

De tels litiges nous aident à mieux cerner les intérêts et les valeurs en cause dans tout différend portant sur le droit de disposer de substances et de tissus humains, quels qu'ils soient, et sur les obligations incombant au dépositaire. La popularité croissante des banques de tissus risque par exemple de susciter des difficultés assez grandes, à cet égard, sur les plans juridique et médical[420]. Dans les formulaires de consentement que font signer les banques de sang canadiennes dans le cas de dons « autologues », il est précisé que le sang ainsi déposé est considéré comme appartenant au donneur ; il en va de même pour le stockage de substances reproductives[421] et génétiques aux États-Unis[422].

c) *Utilisation de substances ou de tissus corporels sans le consentement de l'intéressé*

La règle relative au consentement à l'acte médical protège le patient contre toute atteinte non autorisée à l'intégrité corporelle. Le fait de reconnaître l'existence d'un droit de

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416. *York*, précité, note 415, 425-427, n. 5 en particulier (le tribunal a confirmé le droit des patients d'intenter une poursuite sur la base de droits contractuels et de droits de propriété, et a conclu à l'existence d'un contrat implicite de dépôt à cause de la formule de consentement éclairé relative à la substance reproductive congelée). Peu après la reconnaissance par le tribunal du droit du couple infertile d'intenter une telle poursuite, les parties sont parvenues à un règlement amiable, en vertu duquel le couple a transféré l'embryon.

417. Trib. gr. inst. Créteil, 1er août 1984, *Parpalaix* c. *CÉCOS*, Gaz. Pal. 1984. 2e sem. Jur. 560. Cette affaire est commentée dans D.J. Jones, *loc. cit.*, note 163. Voir également R.P. Jansen, « Sperm and Ova as Property » (1985), 11:3 *J. Med. Ethics* 123.

418. Voir D.J. Jones, *loc. cit.*, note 163, 528-529.

419. Voir *id.*, 529.

420. Voir *supra*, pp. 27-32.

421. Ethics Committee of the American Fertility Society, « Ethical Considerations of the New Reproductive Technologies » (1986), 46:3 (Suppl. 1) *Fertil. Steril.* 89 ([Traduction] « Il est entendu que les gamètes et les produits de la conception sont la propriété des donneurs »).

422. Voir les formulaires de consentement d'Autologous Inc., société dont il est question dans A. Gilmore, *loc. cit.*, note 183. Voir également ASHG, *loc. cit.*, note 167, 782 ([Traduction] « L'ADN stocké est la propriété du déposant, sauf stipulation contraire »).

propriété sur les substances corporelles pourrait-il, de la même façon, interdire l'utilisation ou l'élimination, sans le consentement de l'intéressé, des substances corporelles ou des tissus prélevés[423] ? Cette idée a récemment été abordée par la Cour suprême du Canada, lorsqu'elle a jugé que le fait pour un médecin de prélever et d'utiliser un échantillon du sang d'un patient sans le consentement de celui-ci constituait une saisie abusive aux termes de la *Charte canadienne des droits et libertés*[424].

Après avoir prélevé l'échantillon (le patient, inconscient, avait été amené à l'hôpital à la suite d'un accident de la circulation), le médecin l'a remis à un agent de police. L'échantillon, une fois analysé, a été utilisé en vue d'établir l'infraction de conduite avec facultés affaiblies. On pourrait conclure, à la lecture du jugement, qu'il existe un lien entre l'autonomie (au sens fort) du patient, l'intégrité corporelle, la dignité humaine, et le droit de propriété sur son propre corps :

> Comme j'ai tenté de le montrer précédemment, *l'utilisation du corps d'une personne, sans son consentement, en vue d'obtenir des renseignements à son sujet, constitue une atteinte à une sphère de la vie privée essentielle au maintien de sa dignité humaine*. [. . .] Il était parfaitement raisonnable pour un médecin qui s'était vu confier la tâche de soigner un patient d'agir ainsi. Cependant, je me dois de souligner que la seule raison qui justifiait le médecin de recueillir l'échantillon de sang était qu'il devait servir à des fins médicales. Il n'avait pas le droit de recueillir le sang de M. Dyment pour d'autres fins. *Je ne souhaite pas analyser la question en fonction de considérations relatives à la propriété, bien que ce ne serait pas trop forcer les choses que de le faire*. Certaines provinces attribuent expressément la propriété des échantillons de sang à l'hôpital, ce qui, selon moi, est tout à fait sans importance. [. . .] Plus précisément, je pense que la protection accordée par la *Charte* va jusqu'à interdire à un agent de police, qui est un mandataire de l'État, de se faire remettre une substance aussi personnelle que le sang d'une personne par celui qui la détient avec l'obligation de respecter la dignité et la vie privée de cette personne[425].

d) Droit de propriété et dignité de la personne

L'idée que le concept de propriété puisse permettre de protéger les valeurs fondamentales liées à la dignité de la personne a été débattue dans une décision américaine récente d'une portée internationale. Dans la cause *Moore* c. *Regents of the University of California*[426], un patient atteint de leucémie prétendait que, à son insu et sans qu'il y ait consenti, ses médecins traitants avaient utilisé ses cellules et ses tissus en vue de développer et de breveter un médicament anticancéreux doté d'une grande valeur commerciale. Ce médicament avait été mis au point à partir d'une lignée cellulaire produite grâce à la rate du patient, enlevée par les chirurgiens dans le cadre du traitement. Moore prétendait avoir droit à sa juste part des fruits du brevet, en raison de l'usurpation de ses tissus corporels.

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423. Voir B.M. DICKENS, *loc. cit.*, note 414.

424. *R.* c. *Dyment*, [1988] 2 R.C.S. 417.

425. *Id.*, 431-432 [mis en italiques par nos soins].

426. 793 P. 2d 479 (Cal. 1990) (formation plénière), cert. refusé 111 S. Ct 1388 [ci-après, *Moore* (1990)]. Quelques semaines après que la Commission eut terminé la rédaction des recommandations portant sur la « propriété » des tissus et d'autres questions discutées dans le présent document, la Cour suprême de la Californie rendait dans l'affaire *Moore* (1990) une décision fondée sur des principes s'accordant avec ces recommandations. Voir *infra*, pp. 215-216.

La Cour suprême de la Californie a récemment statué sur d'importants aspects de cette affaire. Un tribunal inférieur avait reconnu au patient le droit d'intenter une poursuite sur la base du droit de propriété :

> [TRADUCTION]
> Nous avons examiné cette question avec prudence. Vu l'évolution de la civilisation — la liberté a supplanté l'esclavage ; l'homme, naguère considéré comme susceptible d'appropriation, se voit maintenant reconnaître, sur le plan individuel, une dignité intrinsèque — il est indispensable de faire preuve de prudence en assimilant les tissus humains à des « biens ». Toutefois, il existe une grande différence entre le fait d'avoir un droit de propriété sur son propre corps et le fait d'appartenir à quelqu'un d'autre. [...]
>
> *Par conséquent, l'essence d'un droit de propriété — le droit ultime qu'on peut avoir sur une chose — existe à l'égard de son propre corps.* [...]
>
> *Le patient doit avoir le droit de regard ultime quant à l'usage qui est fait de ses tissus. En décider autrement risquerait de conduire, au nom du progrès médical, à une atteinte massive à la dignité de la personne et aux droits fondamentaux*[427].

En statuant sur la décision rendue par la juridiction inférieure, la Cour suprême de la Californie a reconnu au patient le droit d'intenter une poursuite pour atteinte à l'intégrité corporelle et à la dignité de la personne, mais a limité le fondement de ce recours à des motifs traditionnels d'ordre juridique et médical.

La majorité de la Cour a jugé qu'une poursuite était possible pour manquement aux règles touchant le consentement éclairé et au devoir de loyauté envers le patient. Si les prétentions du patient étaient établies, il fallait en conclure selon elle que le médecin, lorsqu'il avait recommandé l'ablation de la rate, avait un intérêt commercial lié aux tissus du malade ; que cet intérêt non thérapeutique était susceptible de l'influencer dans la recommandation d'un traitement ; que dans de telles circonstances, le patient type souhaiterait normalement être informé de ce possible conflit d'intérêts avant le traitement :

> [TRADUCTION]
> Par conséquent, nous estimons que le médecin qui demande un consentement à son patient en vue d'une intervention médicale est tenu, vu la relation de confiance qui l'unit à lui, et pour obtenir un consentement éclairé, de divulguer l'existence d'intérêts personnels non reliés à la santé du patient, mais susceptibles d'influer sur le jugement du médecin, qu'ils soient de nature économique ou aient trait à la recherche[428].

Les juges de la minorité, tout en convenant que le patient devrait pouvoir intenter une poursuite pour de tels motifs, estimaient que c'est la notion de droit de propriété qui permettrait le mieux de protéger son intégrité corporelle, sa dignité et d'autres droits fondamentaux liés à la notion de *privacy*.

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427. *Moore* c. *Regents of the University of California*, 249 Cal. Rptr. 494, 504, 506, 508 (App. 2d Dist. 1988) [mis en italiques par nos soins] [ci-après, *Moore* (1988)], confirmé et infirmé en partie par *Moore* (1990), précité, note 426. Voir le texte accompagnant la note 424, *supra*.

428. *Moore* (1990), précité, note 426, 485. Comparer avec MEDICAL ASSOCIATION, COUNCIL ON SCIENTIFIC AFFAIRS, « Conflicts of Interest in Medical Center/Industry Research Relationships » (1990), 263:20 *JAMA* 2790.

La divergence de vues, parmi les membres du tribunal, sur la question du droit de propriété tient en partie à un désaccord sur le droit existant. Les juges de la majorité et de la minorité avaient en effet des opinions nettement différentes sur les points suivants : (1) Une loi adoptée par un État pour régir le droit de disposer de tissus enlevés sur un patient éteint-elle le droit de regard (relevant du droit de propriété) dont le patient jouit, avant l'intervention, sur l'usage qui sera fait du tissu à la suite de l'ablation ? (2) La lignée cellulaire brevetée et le médicament mis au point grâce à elle étaient-ils des produits distincts inventés à partir de matières premières, ou bien les fruits des caractéristiques tout à fait uniques des cellules de Moore, ce qui ferait de ce dernier un co-inventeur ? (3) Les protections prévues par le droit fédéral en matière de propriété intellectuelle ont-elles une incidence sur une poursuite — fondée sur le droit de propriété — intentée à cause d'un usage non autorisé des tissus prélevés, en particulier pour la période de six ans écoulée entre l'intervention chirurgicale et l'obtention du brevet, durant laquelle on avait périodiquement prélevé sur Moore des substances corporelles afin, selon lui, de répondre à des besoins de recherche et de commercialisation[429] ?

La majorité et la minorité s'opposaient en outre fortement sur des questions d'une nature plus générale, comme celle de savoir s'il revient aux tribunaux ou au législateur de juger si le fait de permettre aux patients d'intenter des poursuites d'un type nouveau, fondées sur un droit de propriété sur leur corps, serait susceptible d'avoir des effets destructeurs au plan de la recherche médicale. Sans exclure totalement la possibilité de telles poursuites, la majorité a conclu qu'il n'était pas urgent d'en reconnaître la légitimité, vu la protection offerte selon elle par les règles touchant le consentement éclairé et les devoirs du médecin relevant de l'éthique de la profession. Les juges de la minorité, au contraire, ont soutenu que la nécessité d'empêcher tout enrichissement injuste ainsi que l'exploitation physique et morale des patients l'emportait sur les préoccupations que soulève la possibilité de telles poursuites. Ils ont fait valoir en outre que les relations commerciales et les ambiguïtés caractérisant cette affaire — les règles touchant le consentement éclairé et les devoirs ressortissant à l'éthique médicale s'étendent-ils aux sociétés pharmaceutiques et aux sociétés spécialisées dans la biotechnologie ? — amenaient à conclure que les patients seraient insuffisamment protégés si on ne leur permettait pas d'invoquer un droit de propriété sur leur corps et sur les produits de celui-ci[430].

La vive divergence d'opinions constatée parmi les juges appelés à statuer sur l'affaire *Moore* devrait permettre la cristallisation des enjeux dans les délibérations des législateurs et des tribunaux à l'extérieur de la Californie[431]. Il ne s'agit nullement en effet d'un

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429. *Moore* (1990), précité, note 426, 491-493, 501, 503, 508-512. En parallèle avec la divergence d'opinions entre la majorité et la minorité, le droit des biens comporte d'une part des principes suivant lesquels une personne a droit à la valeur ajoutée par d'autres personnes à une chose qui lui appartient ; et, d'autre part, des principes suivant lesquels on acquiert la propriété d'une chose en transformant des matières premières en une nouvelle forme ou un nouveau type de bien, comme dans la fabrication de vin à partir du raisin. Comparer *Firestone Tire c. Industrial Acceptance Corp.*, [1971] R.C.S. 357 (accession) ; *Jones c. De Marchant*, [1916] 10 W.W.R. 841 (C.A. Man.) (accession) ; C.C. art. 429, 430, 433-435 ; Scottish Law Commission, *Corporeal Movables: Mixing Union and Creation*, Édimbourg, la Commission, 1976.

430. *Moore* (1990), précité, note 426, 493, 496, 500, 506, 516-517, 519-521.

431. Voir, par exemple, Ernest D. Prentice et autres, « An Institutional Policy on the Right to Benefit from the Commercialization of Human Biological Material » (1990) 18:1-2 *L. Med. Health Care* 162.

incident isolé. Un rapport de l'administration américaine fait état d'autres litiges portant sur des demandes de brevets à l'égard de substances biologiques humaines[432]. Plus récemment, une patiente a prétendu que l'hôpital avait, à son insu et sans qu'elle y consente, remis des produits prélevés sur son corps (sang, placenta, cordon ombilical) à une société californienne de biotechnologie, en vue du développement d'un médicament dérivé de l'ADN recombinant, l'activateur tissulaire de plasminogène (ATP), qui a été breveté et qui est désormais utilisé sous licence au Canada pour dissoudre les caillots sanguins après une crise cardiaque[433]. Si les litiges relatifs au développement et à l'utilisation commerciale des tissus humains et des substances biologiques attirent l'attention aux États-Unis[434], ils peuvent également avoir une incidence notable à l'étranger.

L'affaire *Moore* présente-t-elle un intérêt pour le Canada ? Le développement de produits sanguins et de médicaments à partir du placenta humain, de vaccins à partir de tissus fœtaux, montre que l'exploitation thérapeutique et commerciale des substances biologiques humaines fait partie de l'histoire médicale canadienne[435]. Les industries biotechnologique et pharmaceutique canadiennes font des recherches sur des substances biologiques humaines en vue de découvrir des utilisations commerciales et autres[436]. La biotechnologie accélère la vitesse à laquelle la science médicale parvient à convertir des tissus humains autrefois dénués de toute valeur en des substances thérapeutiques ayant une valeur commerciale. La maxime juridique « *de minimis non curat lex* » (le droit ne s'occupe pas des affaires insignifiantes) n'est sans doute plus applicable au prélèvement de tissus et de substances longtemps considérés comme sans valeur et laissés pour compte :

> [TRADUCTION]
> *Jusqu'à récemment, on croyait que le corps humain, par rapport au mental et au spirituel, avait peu de valeur, sauf en tant que source de travail. Or, ces derniers temps, nous l'avons vu revêtir sous certains aspects une valeur incroyable.* Dans la présente affaire, par exemple, on nous dit que les cellules de John Moore pourraient à elles seules devenir la pierre angulaire d'une entreprise de plusieurs milliards de dollars grâce à laquelle les titulaires des brevets pourraient faire fortune. *Pour le meilleur ou pour le pire, nous sommes irrémédiablement entrés dans une ère qui nous force à remettre en question la façon dont nous concevons les droits relatifs aux cellules et au corps humain ainsi que les relations juridiques y afférentes*[437].

On assiste également, en parallèle, à des changements sur le plan du droit. La reconnaissance juridique aux États-Unis des brevets relatifs à des formes de vie[438], qui a fait augmenter de 300 % le nombre de demandes de brevets pour des inventions liées

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432. Voir G.B. WHITE, *op. cit.*, note 91, pp. 23-27.

433. *Potts* c. *Genentech* (1er novembre 1988), Santa Clara Cnty 670331 (Cal. Sup. Ct).

434. Voir par exemple, *United States* c. *Garber*, 607 F. 2d 92 (5th Cir. 1979) (les revenus tirés de la vente de plasma par le « donneur » sont-ils imposables ?).

435. Voir *infra*, section III.A(1) et *supra*, ch. I, section I.B.

436. Voir *Répertoire de la biotechnologie industrielle canadienne*, Ottawa, Ministère d'État aux Sciences et à la Technologie, 1988.

437. *Moore* (1988), précité, note 427, 504 [mis en italiques par nos soins].

438. Voir *infra*, note 777.

à des substances biologiques humaines[439], s'est également produite au Canada, où des brevets ont été accordés dès le début des années quatre-vingt pour des lignées cellulaires humaines[440]. Il semble donc que l'utilisation de substances cellulaires et de gènes humains dans la fabrication de produits thérapeutiques fasse en droit canadien aussi l'objet d'une protection relevant de la propriété intellectuelle et permettant une exploitation commerciale exclusive.

La convergence de ces situations inédites dans les domaines médical et juridique accroît les risques de conflits entre les utilisateurs de cellules et de tissus humains, et les personnes sur lesquelles ceux-ci sont prélevés. Les différences culturelles et juridiques entre les États-Unis et le Canada aideront peut-être notre société à éviter cet écueil, pendant le passage à l'ère de la biotechnologie. Chose certaine, toutefois, les transformations en cours forcent la société à revoir les règles établies en matière de prélèvement d'organes et de tissus. Les litiges comme celui de l'affaire *Moore* sont peut-être le symptôme d'une révolution technico-juridique, révolution qui perturbe la structure juridique existante au point où la société doit inévitablement traverser une période de confusion et de heurts avant de pouvoir établir un nouveau régime juridique, ou adapter l'ancien[441]. C'est en fait le contenu même de la notion d'intégrité corporelle morale et physique qui se trouve remis en cause par la biotechnologie.

Considérées globalement, les décisions *Moore*, *Parpalaix* et *Dyment* portent en outre à conclure que les chercheurs devraient tenir compte des droits de la personne dans leurs travaux. La reconnaissance d'un droit de propriété restreint constituera-t-elle une protection efficace, dans les cas — rares sans doute — où certaines substances corporelles ont été exploitées commercialement sans l'autorisation expresse et spécifique du patient ? Les droits de la personne ne sauraient être absolus dans une société pluraliste ; mais par quels moyens juridiques peut-on favoriser leur primauté[442] ? En modifiant les règles régissant les brevets d'invention ? En forçant médecins et chercheurs à renseigner l'intéressé sur les possibilités commerciales ou autres que recèlent les travaux sur les tissus prélevés[443] ? En reconnaissant l'existence d'un droit de propriété restreint sur les produits du corps humain ? Envisagées dans le contexte du XVIII[e] siècle, de telles solutions sembleraient abominables du point de vue de l'éthique et du droit. Toutefois, le droit et la médecine

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439. *Ibid.*

440. Voir *infra*, pp. 143-144, l'analyse de la *Loi sur les brevets*.

441. Voir Vincent M. BRANNIGAN, « Biotechnology: A First Order Technico-Legal Revolution » (1988), 16 *Hofstra L. Rev.* 545, 546-550.

442. L'opinion de chacun sur l'opportunité de recourir aux droits ressortissant à la propriété pour assurer la protection des droits de la personne dans ce domaine semble liée dans une large mesure à son opinion quant à l'application, en la matière, d'une notion de propriété fondée sur la personne, sur le travail, sur la possession, etc. Voir M.R. COHEN, « Property and Sovereignty » (1927), 13 *Cornell L.Q.* 8. Voir aussi Margaret Jane RADIN, « Property and Personhood » (1982), *Stan. L. Rev.* 957, 966.

443. Comparer Note, « Ownership of Human Tissue: Life after *Moore* v. *Regents of the University of California* » (1989), 75 *Va. L. Rev.* 1363, 1391-1392 et Randy W. MARUSYK et Margaret S. SWAIN, « A Question of Property Rights in the Human Body » (1989), 21 *Rev. d'Ottawa* 351.

sont en perpétuelle évolution. Citons à ce propos un juriste canadien : [TRADUCTION] « Le concept de propriété n'est pas statique. L'institution comme telle, la façon dont on la perçoit, et partant la signification du terme changent toutes les trois au fil du temps[444]. » Il serait sans doute opportun pour la société — dans la perspective des droits de la personne à l'aube du XXI[e] siècle — de se demander si l'établissement, à l'égard des tissus humains, d'un droit de propriété d'une portée limitée serait la meilleure façon de protéger l'intégrité corporelle, l'autonomie de l'individu et les valeurs fondamentales attribuées à la personne humaine.

Pour diminuer les risques de litiges entre les « fournisseurs » de produits du corps humain et ceux qui en font un usage commercial, on pourrait se fonder tout d'abord sur la relation de confiance entre médecins et patients. Lorsqu'une personne a recours aux services d'un médecin, elle lui fait confiance et s'attend à ce que les interventions pratiquées sur son corps le soient pour son bien. Certains tribunaux ont considéré cette attente comme un droit, qui impose au médecin le devoir correspondant d'agir avec la plus grande loyauté[445]. Les droits moraux et juridiques liés à cette éthique axée sur l'intérêt du patient sont depuis longtemps la marque des relations entre médecin et patient[446]. Lorsqu'un intérêt se manifeste, qui risque d'entrer en conflit avec le devoir du médecin d'exercer un jugement professionnel objectif au sujet de son patient, le premier est tenu, vu son devoir de loyauté, d'en informer le second et de ne pas continuer le traitement avant d'obtenir son consentement éclairé. Dans le cas qui nous intéresse, cela signifie que le médecin aurait l'obligation de divulguer tout intérêt commercial potentiel relatif aux produits du corps du patient[447]. Si le patient, dûment informé, donne un consentement éclairé, le traitement pourrait être poursuivi. En revanche, si le patient refuse de continuer à prêter son concours, le médecin aurait l'obligation de confier son patient à un confrère ou à une consœur ; cette obligation lui incomberait également dans le cas où il conclurait que son intérêt commercial risque manifestement de compromettre la neutralité de son jugement professionnel.

Le recours à différents concepts de la common law — devoirs découlant de la relation de confiance (*fiduciary duties*), consentement éclairé, droit de propriété — risque cependant de ne pas fournir des réponses aussi claires ou aussi certaines qu'on le souhaiterait quant aux intérêts, aux droits et aux devoirs divergents des acteurs en présence : patients, médecins, chercheurs, hôpitaux, sociétés œuvrant dans le domaine de la biotechnologie. La complexité des questions et des intérêts en jeu justifierait une étude pluridisciplinaire,

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444. C.B. MACPHERSON (dir.), *Property: Mainstream and Critical Positions*, Toronto, University of Toronto Press, 1978, p. 1.

445. Voir E.I. PICARD, *op. cit.*, note 364, p. 3 ([TRADUCTION] « Le médecin [...] se trouve dans une relation de confiance avec son patient. Il s'ensuit donc qu'il a le devoir d'agir de bonne foi : il ne doit jamais permettre que son devoir professionnel entre en conflit avec ses intérêts personnels ; il ne doit pas induire son patient en erreur »). Voir également *Rowe* c. *Grand Trunk Railway* (1866), 16 U.C.C.P. 500, 506 (C.A.) ; *Kenny* c. *Lockwood*, [1932] 1 D.L.R. 507 (C.A. Ont.).

446. Voir Robert M. VEATCH, *A Theory of Medical Ethics*, New York, Basic Books, 1981, p. 22.

447. Comparer, CONSEIL DES SCIENCES DU CANADA, *La génétique et les services de santé au Canada*, Rapport n° 42, Ottawa, le Conseil, 1991, p. 85 et le COMITÉ CONSULTATIF NATIONAL D'ÉTHIQUE POUR LES SCIENCES DE LA VIE ET DE LA SANTÉ, *infra*, note 956.

par laquelle on tenterait de déterminer comment la société pourrait parvenir à un juste équilibre entre la nécessité d'encourager le développement, grâce à la biotechnologie, de médicaments obtenus à partir de tissus humains, et la protection des droits fondamentaux de la personne.

C. Vente de produits du corps humain

Si deux personnes passent un contrat portant sur la vente de fins cheveux roux, ce contrat sera-t-il valable devant le tribunal ? Et si c'est du sang, des cellules, du lait maternel, de la moelle osseuse, des organes, un cadavre qui font l'objet du contrat ? Quelle importance faut-il accorder au fait que dents et cheveux sont commercialisés depuis des siècles, alors que l'intérêt commercial des ventes d'organes et de parties du corps ne s'est vraiment fait jour que depuis quelques décennies[448] ?

Les textes législatifs provinciaux apportent certains éléments de réponse à ces questions[449]. Toutefois, la théorie du droit des contrats permet également, en ce qui a trait à la vente de tissus, d'organes et de produits du corps humain, de comprendre l'évolution de la mentalité collective et de la politique établie par les autorités. Elle est en outre applicable à la vente des produits du corps humain dont les dispositions législatives provinciales n'interdisent pas la vente — lait maternel, sang, sperme, cellules, etc.[450].

Il y a peu de jurisprudence sur le sujet. Cela tient sans doute à ce que c'est principalement au cours des dernières décennies qu'on a vu croître l'utilisation et la valeur des éléments composant le corps humain. Il ressort tout de même des décisions rendues par les tribunaux et de la théorie des contrats que la validité des conventions portant sur la vente de produits du corps humain est assujettie à deux conditions : premièrement, le consentement des parties doit avoir été donné librement et sans contrainte ; deuxièmement, la convention ne doit porter atteinte ni à l'intérêt public ni à l'ordre public — elle ne doit être ni illégale, ni immorale, ni manifestement néfaste pour la collectivité[451].

(1) Contrats, consentement et équité

Le droit reconnaît depuis longtemps le principe de la liberté contractuelle ; en fait, tout contrat est d'une manière générale présumé exécutoire[452]. Mais lorsqu'une personne a contracté des engagements à un moment où elle se trouvait dans la détresse, les tribunaux peuvent s'enquérir des circonstances afin de vérifier l'absence de toute contrainte :

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448. Voir R. SCOTT, *op. cit.*, note 268, p. 180.

449. On trouvera aux pages 151-158, *infra*, des considérations sur l'interdiction de la vente dans les lois provinciales et le *Code civil du Québec*.

450. *Ibid.*

451. Voir, *infra*, le texte accompagnant la note 466.

452. Patrick S. ATIYAH, *The Rise and Fall of Freedom of Contract*, Oxford, Clarendon Press, 1979, p. 526.

[TRADUCTION]
[L]e tribunal d'« equity » tentera de déterminer si les parties ont contracté d'égal à égal ; s'il conclut que le vendeur était dans une situation de détresse et qu'on en a profité, il annulera le contrat[453].

Le droit des contrats, par ailleurs, exige depuis longtemps que toute convention soit conforme, en gros, aux principes de l'équité et de l'égalité. Dans le cas de l'équité, il s'agit de se demander si le contrat revêtait un caractère oppressif lorsque les parties l'ont conclu, ou encore s'il a été conclu sous la contrainte des circonstances du moment ou en raison d'une influence abusive. De la même manière, en droit civil, la crainte raisonnable et présente d'un « mal sérieux » peut invalider le consentement et provoquer la nullité d'un contrat[454]. Il peut donc arriver qu'un tribunal conclue, au nom du principe de l'équité, à la non-validité d'un contrat.

On ne trouve dans la jurisprudence canadienne publiée aucune décision sur des conventions ayant trait à la vente de parties du corps humain. Cependant, des affaires de « vente de bébé » survenues aux États-Unis et chez nous font ressortir les principales difficultés que soulèvent ce type d'ententes. En matière d'adoption, par exemple, les tribunaux américains se sont demandé dans le cadre de certaines causes si la mère biologique avait consenti librement à se séparer de son enfant[455]. Dans un cas où le contrat d'adoption a été jugé non valide, l'état de pauvreté de la mère biologique et la somme qui lui avait été versée ont convaincu le juge d'un tel « abus d'influence » ou d'une telle « contrainte » qu'elle ne pouvait pas avoir consenti librement à l'adoption[456]. Des motifs semblables ont amené un tribunal à annuler un contrat de maternité de substitution dans la désormais célèbre affaire *Baby M*[457]. En revanche, un tribunal canadien a conclu à la liberté du consentement dans le cas d'une mère biologique ayant reçu des parents adoptifs une somme raisonnable pour le remboursement des frais judiciaires et de déplacement nécessités par le processus d'adoption[458].

Dans quelle mesure les principes exprimés dans ces décisions sont-ils applicables aux contrats de vente portant sur des tissus humains, des parties du corps ou des substances

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453. S.M. WADDAMS, *The Law of Contracts*, 2e éd., Toronto, Canada Law Book, 1984, p. 382, citant *Wood* c. *Abrey* (1818), 3 Madd. 417, 423. Voir également *Mundinger* c. *Mundinger* (1968), 3 D.L.R. (3e) 338 (C.A. Ont.), confirmé à [1970] R.C.S. vi (annulation du contrat de vente d'un terrain, parce qu'une des parties était en proie à des troubles émotifs et venait de se séparer d'avec son conjoint).

454. Voir S.M. WADDAMS, *op. cit.*, note 453, pp. 376, 384 ; AMERICAN LAW INSTITUTE, *Restatement of the Law, Second of Contracts*, 2e éd., vol. 2, St. Paul (Minn.), American Law Institute Pub., 1973- , art. 173, 177 ; Robert W. CLARK, *Inequality of Bargaining Power*, Toronto, Carswell, 1987, pp. 93, 207. Pour la doctrine civiliste, voir Jean-Louis BAUDOUIN, *Les Obligations*, Cowansville (Qc), Yvon Blais, 1983, pp. 122-124, où figure une analyse des art. 994 et 995 C.c.

455. Voir, pour des observations de nature générale, Jack W. SHAW, « What Constitutes Undue Influence in Obtaining a Parent's Consent to Adoption of Child », 50 A.L.R. 3d 918.

456. Voir *In Re G*, 389 S.W. 2d 63, 69 (Mo. App. 1965). Voir également *Gray* c. *Maxwell*, 293 N.W. 2d 90, 95 (Neb. 1980). Voir cependant *Barwin* c. *Reidy*, 307 P. 2d 175, 185 (New Mex. 1957) (on a jugé qu'il ne s'agissait pas d'une contrainte susceptible d'entraîner l'annulation d'un contrat).

457. Voir *Baby M*, 537 A. 2d 1227, 1249 (N.J. 1988).

458. *Re Female Infant* (1982), 34 B.C.L.R. 177 (C.S.) (requête en adoption accueillie).

corporelles ? Certes, il n'y a dans de tels contrats ni transmission juridique d'un être humain, ni nécessité de protéger les intérêts de l'enfant. En l'absence d'une tierce partie innocente, on pourrait faire valoir que les adultes doués de discernement devraient d'une manière générale être libres de conclure des conventions relatives à la vente de parties du corps, et que la société ferait preuve d'un paternalisme illégitime en s'y opposant[459].

Cet argument tend à assimiler la liberté économique à l'affirmation de la liberté individuelle. Mais si l'on voit également dans la liberté le pouvoir de favoriser et de protéger la dignité de la personne humaine, on pourra estimer au contraire qu'il est souhaitable, du point de vue même de la liberté, d'interdire la vente de tissus au nom de cette dignité[460]. Dans ce sens, les concepts juridiques de « contrainte » et d '« abus d'influence » pourraient être applicables à toutes les situations où la décision d'opter pour la vente de tissus humains — ou d'y consentir — ne peut être prise en toute liberté, que cela tienne à des raisons médicales ou à des raisons économiques. Lorsqu'un adolescent est atteint d'une leucémie fatale, les parents pourront considérer comme parfaitement raisonnable le fait d'offrir la somme de 5 000 $ pour essayer de trouver un donneur compatible de moelle osseuse[461]. De la même manière, une personne sans emploi depuis trois ans, constatant que des centaines de patients attendent une transplantation, ne rejettera peut-être pas du revers de la main la possibilité de vendre un de ses reins pour la somme de 32 000 $[462]. Du reste, des auteurs et des groupes de travail au Canada, aux États-Unis et en Europe ont fait valoir que la vente d'organes et de tissus humains risque de constituer une incitation à l'exploitation économique des pauvres[463]. Dans une perspective plus large, le débat portant sur la question de savoir si la vente accentue ou atténue le désespoir économique est le reflet d'une divergence d'opinions au sujet d'une question plus fondamentale, liée à la justice distributive : quelle incidence concrète peut avoir la décision d'interdire ou d'autoriser la vente de tissus humains sur le problème de la répartition hautement inéquitable des richesses dans la société[464] ?

(2) Ententes contraires à l'ordre public

Les tribunaux pourraient refuser de donner effet à certains contrats de vente portant

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459. Bernard M. DICKENS, « Legal and Ethical Issues in Buying and Selling Organs » (1987), 4 *Transplantation/Implantation Today* 15, 20 ([TRADUCTION] « Toutefois, l'opinion selon laquelle la liberté de choix dont jouissent les pauvres est protégée ou favorisée lorsqu'on les empêche de profiter d'une telle occasion de réaliser un gain est elle-même inacceptable du point de vue de l'éthique pour plusieurs motifs. Elle refuse aux pauvres une source de revenus à laquelle d'autres ont accès, elle n'atténue aucunement la pauvreté qui est tenue pour une cause d'exploitation et elle témoigne d'un paternalisme injustifiable. Les pauvres n'ont pas plus besoin que les autres d'être protégés contre l'exploitation et peuvent tout autant que les autres décider eux-mêmes d'accepter ou de refuser une source de revenus sans que leur liberté à l'égard de décisions futures en souffre. »).

460. Voir Margaret Jane RADIN, « Market-Inalienability » (1986-1987) 100 *Harv. L. Rev.* 1849, 1899.

461. Voir Gina KOLATA, « Transplant Reward Offer Raises Furor », *New York Times* (23 juin 1989) A6.

462. Voir Mike KING, « Unemployed Nurse Offers to Sell Kidney », *The [Montreal] Gazette* (17 juillet 1989) A3.

463. Voir USTF, *op. cit.*, note 29, p. 98 ; R.M. TITMUSS, *op. cit.*, note 244, p. 219 (sang) ; Margaret A. SOMERVILLE, « Access to Organs for Transplantation: Overcoming "Rejection" » (1985), 132:2 *Journal de l'Association médicale canadienne* 113. Voir cependant B.M. DICKENS, *loc. cit.*, note 459.

464. Voir M.J. RADIN, *loc. cit.*, note 460, 1911.

sur des éléments ou des produits du corps humain parce qu'ils sont en droit tenus pour nuls et contraires à l'ordre public :

> [TRADUCTION]
> Il incombe aux tribunaux de donner effet aux contrats [...] puisque nous vivons dans une société où la primauté du droit est établie ; *mais il existe des cas où les règles de droit ne peuvent recevoir leur effet parce que la loi elle-même reconnaît certaines considérations d'ordre public qui prévalent sur des intérêts et sur ce qui, autrement, serait tenu pour des droits et des pouvoirs conférés à l'individu*. Selon nous, il est important de ne pas oublier que c'est ainsi que s'applique le principe de l'ordre public : il s'agit de dérogations aux droits et aux pouvoirs de particuliers qui normalement seraient confirmés en vertu des principes du droit[465].

Le *Code civil du Québec* reconnaît un principe semblable en exigeant que les contrats ne soient pas contraires « aux bonnes mœurs ou à l'ordre public »[466].

Pour savoir si un contrat est contraire à l'ordre public, il faut se demander s'il s'oppose à certains principes juridiques établis ou à des normes juridiques plus générales et en évolution constante. Un contrat par lequel quelqu'un s'engage à commettre un acte criminel, par exemple, est à la fois nul et illégal[467]. L'infraction criminelle de la common law britannique du XVIII^e^ siècle consistant dans la vente de cadavres semble avoir été reprise dans le *Code criminel* du Canada[468] ; s'il en est ainsi, un contrat qui porterait sur la vente d'un cadavre serait nul et contraire à l'ordre public[469], vu son illégalité. Dans la société canadienne moderne, d'autres contrats sont souvent désignés comme illégaux dans des textes législatifs — mentionnons par exemple les lois provinciales interdisant la vente d'organes ou de bébés[470]. Les tribunaux ne pourraient non plus, en règle générale, leur donner effet parce qu'ils sont contraires à l'ordre public[471].

Qu'en est-il cependant du sang, de la peau, de la moelle osseuse, du sperme, des cheveux et des autres produits du corps semblables, dont la vente n'est pas interdite par des textes provinciaux[472] ? Il n'est pas certain que les contrats portant sur la vente de tels produits soient « contraires à l'ordre public ». Le fait qu'il paraît ressortir de certaines dispositions du Code civil que la vente de parties du corps est « hors du commerce », alors que dans d'autres dispositions le législateur semble envisager l'échange à titre onéreux de tissus susceptibles de régénération, porte à croire que la question n'y a pas été tranchée

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465. *Re Millard*, [1938] R.C.S. 1, 4 [mis en italiques par nos soins].

466. C.c., art. 990 (« La considération est illégale quand elle est prohibée par la loi, ou contraire aux bonnes mœurs ou à l'ordre public. ») ; voir également l'art. 1062 (« L'objet d'une obligation doit être une chose possible, qui ne soit ni prohibée par la loi, ni contraire aux bonnes mœurs. »).

467. Voir *Byron* c. *Tremaine* (1899), 29 R.C.S. 445 (contrat d'extorsion). Voir également S.M. WADDAMS, *op. cit.*, note 453, pp. 413-414.

468. Voir *infra*, pp. 127-131, analysant l'art. 182 du *Code criminel*.

469. Voir S.M. WADDAMS, *op. cit.*, note 453, p. 412.

470. Voir *infra*, note 499 (bébés) et la section III (organes).

471. Voir S.M. WADDAMS, *op. cit.*, note 453, p. 421.

472. Voir *infra*, pp. 155-156.

de manière définitive[473]. Les contrats de vente de tissus humains ne sauraient manifestement pas être rangés dans certaines catégories de contrats considérés comme non valides, notamment celles qui ressortissent aux « pratiques restrictives du commerce » ou à la « vente de charges publiques »[474]. Ils se rapprochent plutôt de certaines autres catégories, notamment les « ententes contraires aux bonnes mœurs » ou les « ententes nuisant aux liens familiaux ».

Par exemple, on pourrait soutenir que la vente de sperme ou de gamètes est contraire à l'ordre public parce qu'elle porte atteinte aux bonnes mœurs et qu'elle nuit aux rapports familiaux[475]. Un tribunal de Paris a conclu qu'un contrat relatif à la vente d'une partie tatouée de la peau d'une personne était « illicite, immoral et contraire à l'ordre public[476] ». Par « ententes immorales », toutefois, on entend habituellement celles qui concernent des pratiques sexuellement répréhensibles[477]. La question de savoir si, de nos jours, la vente de sperme en vue du traitement de l'infertilité est immorale ou si elle constitue une pratique sexuellement répréhensible n'est pas tranchée. Si, au XIX^e siècle et au début du XX^e siècle, les tribunaux considéraient l'insémination artificielle comme un adultère, un acte immoral et une menace pour les relations familiales, ils tendent désormais à le considérer comme un traitement médical entraînant des conséquences juridiques particulières[478]. Quant aux ententes pourtant sur la cohabitation, autrefois considérées comme « immorales », les tribunaux leur donnent maintenant effet, en règle générale, et il est même parfois recommandé d'en conclure[479]. D'une époque à l'autre, bref, les définitions sociale et juridique de l'ordre public, de ce qu'est un contrat contraire aux bonnes mœurs, ne sont pas les mêmes :

> [TRADUCTION]
> Les définitions de cette nature ne peuvent être fixées en catégories établies à une époque donnée parce que, ainsi que l'observait un tribunal américain, la conception de l'ordre public à telle époque peut être entièrement contraire à celle ayant cours à une autre époque. La conception de l'ordre public dans une société ne se transforme pas simplement

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473. Comparer les art. 19, 20, 1059 du C.c. Pour une description du débat relatif à l'opposition vénalité-gratuité qui a marqué l'élaboration des articles du Code civil, voir F. HELEINE, *loc. cit.*, note 365, 55-63. Comparer Jean-Christophe GALLOUX, « Réflexions sur la catégorie des choses hors du commerce : l'exemple des éléments et des produits du corps humain en droit français » (1989), 30 *C. de D.* 1011 et Marie-Angèle HERMITTE, « Le corps hors du commerce, hors du marché » (1988), 33 *Arch. Phil. Dr.* 323. On a récemment proposé des réformes au Code civil qui entraîneraient l'abandon de la distinction entre les produits susceptibles de régénération et ceux qui ne le sont pas, et exigeraient la gratuité pour l'aliénation de produits du corps, de tissus et d'organes. Voir le projet de loi 125, précité, note 380, art. 25.

474. Voir S.M. WADDAMS, *op. cit.*, note 453, pp. 416-419.

475. Voir *Bonisteel* c. *Saylor* (1890), 17 O.A.R. 505 (vente immorale) ; voir également S.M. WADDAMS, *op. cit.*, note 453, p. 413 ; *Farrar* c. *MacPhee* (1971), 19 D.L.R. (3^e) 720 (C.A. Î.-P.-É.) (cohabitation immorale).

476. Trib. gr. inst. Paris, 3 juin 1969, *Dlle X...* c. *Soc. Ulysse — Productions et cons.*, Gaz. Pal. 1969. 2^e sem. Jur. 57.

477. Diana BRAHAMS, « Kidneys for Sale » (1989), 139:6393 *New L.J.* 159. Voir également J.-L. BAUDOUIN, *op. cit.*, note 454, p. 189, n. 33, où l'on cite l'affaire *Langelier Limitée* c. *Demers* (1928), 66 C.S. 120.

478. Comparer *Orford* c. *Orford* (1921), 58 D.L.R. 251 (C.S. Ont.) et *Parpalaix* c. *CÉCOS*, analysé dans D.J. JONES, *loc. cit.*, note 163, 530-531.

479. Comparer Walter H.E. JAEGER, *Williston On Contracts*, 3^e éd., New York, Lawyers Co-operative Pub., 1972, art. 1745 et ALBERTA LAW REFORM INSTITUTE, *Towards Reform of the Law Relating to Cohabitation Outside Mariage*, Rapport n° 53, Edmonton, l'institut, 1989, pp. 23-27.

> à la faveur de bouleversements politiques, mais aussi par suite d'une évolution graduelle. [...] Ces catégories sont fonction des valeurs de l'époque. Toutefois, dans une société en évolution, les valeurs doivent subir des transformations, et le droit ne remplit pas sa fonction sociale s'il n'est pas lui aussi capable d'évoluer[480].

À défaut de mesures législatives expresses, ou encore de principes de common law ou de droit civil, il serait possible, pour déterminer si les contrats de vente relatifs à certains produits du corps humain sont contraires à l'ordre public, de tenir compte des considérations suivantes :

— **Intégrité physique et risques médicaux :** D'une part, le fait de permettre la vente de tissus, d'éléments ou de produits du corps humain pourrait inciter des gens à compromettre leur santé et à prendre des risques physiques injustifiés ; d'autre part, les risques physiques et médicaux liés au don de certains produits du corps — cheveux, sang, sperme, sueur, lait, lignées cellulaires — sont si minimes, pourrait-on faire valoir, que les inquiétudes sont considérablement restreintes[481]. Dans ce dernier cas, on pourrait appliquer la maxime juridique *de minimis non curat lex* (le droit ne s'occupe pas des choses insignifiantes).

— **Communication de renseignements médicaux et protection du receveur :** Certains estiment que les vendeurs, craignant qu'on ne les paie pas si les tissus donnés sont impropres à l'usage qu'on veut en faire, s'abstiennent, par appât du gain, de communiquer certaines données — maladies, hérédité, antécédents médicaux — dont les autorités médicales doivent disposer pour décider s'il y a lieu d'utiliser les tissus prélevés en vue d'une greffe[482].

— **Autonomie et droits fondamentaux :** Pour certains, les présomptions d'ordre éthique et juridique relatives à l'autonomie et à la liberté de l'être humain supposent le droit d'échanger des substances corporelles ou des parties du corps, dans la mesure où cela ne cause aucun préjudice véritable à des tiers[483]. D'aucuns ont même prétendu que ce droit ferait l'objet d'une protection constitutionnelle[484]. D'autres estiment, par contre, que les droits fondamentaux et la liberté individuelle n'emportent pas le droit de vendre des parties du corps ou des substances corporelles[485].

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480. Voir W.M. WADDAMS, *op. cit.*, note 453, pp. 409-410. Voir également W.H.E. JAEGER, *op. cit.*, note 479, p. 93 ([TRADUCTION] « [l]es tribunaux ne peuvent donner effet aux ententes dont l'objet est immoral, en raison de l'ordre public qui, dans certains cas, est fonction des attitudes dominantes dans la société à ce moment-là »).

481. Voir *National Organ Transplant Act*, Pub. L. No. 98-507, 1984 *U.S. Code Cong. & Ad. News* (98 Stat.) 3975, 3982 (1984) (lorsqu'on a décidé, aux É.-U., d'interdire la vente d'organes, on a conclu que l'aliénation des parties du corps susceptibles de régénération ne met pas en péril la santé du donneur).

482. Voir R.M. TITMUSS, *op. cit.*, note 244, pp. 151-153, 219 ; D.J. JONES, *loc. cit.*, note 163, 534, n. 52 ; 50 Fed. Reg. 35,458 et 35,459 (1985) (les données montrent que le sang des donneurs rémunérés présente des risques plus élevés de transmission de l'hépatite que celui des donneurs non rémunérés). Voir également *Gilmore* c. *St. Anthony Hospital*, 598 P. 2d 1200 (Okl. 1979).

483. Voir John Stuart MILL, *La liberté*, Paris, Guillaumin, 1864.

484. Voir *infra*, note 873.

485. Voir *Doe* c. *Kelley*, 307 N.W. 2d 438 (Mich. App. 1981) ; M.J. RADIN, *loc. cit.*, note 460, 1893.

— **Dignité de la personne et droits inaliénables :** Certains prétendent que les droits conférés aux individus par la société comportent le droit inaliénable de ne pas être l'objet d'échanges et de ne pas être traité comme une bien[486]. Ce souci est exprimé dans les principes éthiques qui s'opposent à ce que le corps humain soit réduit à un bien, et exigent qu'on en préserve l'inviolabilité. D'autres répondent que ces préoccupations devraient être mises dans la balance avec le fait qu'en permettant la vente, on favoriserait l'augmentation du nombre de tissus et de substances disponibles pour le traitement de patients[487]. Ils font en outre valoir que certaines produits du corps humain (par exemple, ceux qui se régénèrent) sont tellement éloignés de la notion de personne qu'ils devraient échapper à toute interdiction juridique ou morale touchant la vente d'êtres humains.

— **Équité, universalité, insuffisance des ressources** : Il s'en trouve pour soutenir que l'attribution de substances ou de tissus humains thérapeutiques ne devrait être fonction ni de la capacité de payer ni du prix offert, parce que de telles solutions sont critiquables du point de vue de l'équité et faussent l'application de critères plus importants, notamment les besoins médicaux[488]. L'argument a beaucoup de force dans une économie libérale. Mais dans les sociétés où les frais liés aux greffes et transplantations sont assumés et réglementés par le régime public d'assurance maladie, les craintes et les arguments évoqués ci-dessus perdent de leur impact. Les frais médicaux qu'entraîne le don d'un rein ou de moelle osseuse, par exemple, peuvent être remboursés par l'assurance maladie provinciale du receveur ou par une autre assurance[489]. Si un tarif raisonnable était fixé par règlement, les donneurs seraient moins tentés de rechercher le receveur qui offre la plus forte somme[490].

— **Mise en œuvre et accès :** D'aucuns prétendent que, tout bien considéré, les contrats de vente portant sur des organes ou des produits du corps humain ne devraient pas être autorisés parce qu'il posent des problèmes complexes d'application et de logistique[491]. En revanche, on peut faire valoir que, s'agissant de certaines substances, la réglementation des contrats se fera en général d'elle-même, et que la vente pourrait bien entraîner une augmentation des stocks de produits grâce auxquels on peut sauver des vies[492].

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486. Voir *Adoption of B.A.B.*, 534 A. 2d 1050, 1052 (Pa. 1987) (les êtres humains ne sont pas des marchandises) ; M.J. RADIN, *loc. cit.*, note 460, 1899.

487. J. Robert S. PRITCHARD, « A Market for Babies » (1984), 34 *U.T.L.J.* 341, 352.

488. Voir *Baby Girl D*, 517 A. 2d 925, 927 (Pa. 1986) ([TRADUCTION] « le choix n'est pas uniquement fonction de la richesse des parties » en matière d'adoption). Voir également Susan ROSE-ACKERMAN, « Inalienability and the Theory of Property Rights » (1985), 85 *Colum. L. Rev.* 931, 948.

489. Voir P.G. BLAKE et C.J. CARDELLA, *loc. cit.*, note 121, 774 ; N.A. BUSKARD, *loc. cit.*, note 51.

490. Voir G. SHARPE, *loc. cit.*, note 201 ; B.M. DICKENS, *loc. cit.*, note 459, 21. Voir également les règlements français sur les banques de lait, *infra*, note 934.

491. COMMISSION DE RÉFORME DU DROIT DU MANITOBA, *Report on the Human Tissue Act*, Rapport n° 66, Winnipeg, la Commission, 1986, p. 110 [ci-après CRDM].

492. Russell D. ROBERTS et Michael J. WOLKOFF, « Improving the Quality and Quantity of Whole Blood Supply: Limits to Voluntary Arrangements » (1988), *J. Health Pol. Pol'y L.* 167.

— **Altruisme et accès :** Pour certains, le fait d'autoriser la vente d'organes et de produits du corps humain est une entrave à la politique fondée sur la notion d'altruisme, de don fait en vue de sauver des vies[493]. Ils se font répondre que l'altruisme pur n'est qu'une vue de l'esprit, que la politique suivie jusqu'ici est un échec, les stocks de certains éléments et produits du corps humain demeurant insuffisants, et enfin que le fait de s'en tenir à cette politique prolonge inutilement souffrances et maladies[494]. Les insuffisances de la politique fondée sur l'altruisme pur ne signifient certes pas nécessairement qu'il faut opter pour la commercialisation totale ; mais il y aurait peut-être lieu, en tout cas, d'établir une politique mitoyenne, qui reconnaîtrait les deux types de contrepartie possible — pécuniaire et non pécuniaire — tout en favorisant une augmentation des stocks[495].

Plusieurs de ces considérations, notamment les répercussions possibles sur la protection des donneurs et des receveurs et les problèmes d'application, concernent les conséquences pratiques de la décision d'autoriser ou d'interdire la vente de tissus. D'autres, notamment les effets sur le plan de l'altruisme, renvoient au débat éthique plus fondamental relatif à l'élaboration de régimes au sujet de substances corporelles qui jusqu'ici ont échappé à la commercialisation[496]. Pour certains auteurs, le fait de permettre — fût-ce d'une manière limitée — la vente de tissus humains, ou encore d'appliquer la logique du marché au corps humain, heurte la conception que nous nous faisons de la dignité humaine, de notre corps, de notre moi et de la personne humaine[497].

(3) Remboursement des frais raisonnables

Pour établir la politique régissant la vente d'organes et de produits du corps humain ainsi que les règles de droit connexes, il importe en outre de comprendre les objectifs précis auxquels répond l'autorisation ou l'interdiction de la rémunération des donneurs. Ces objectifs ont en effet d'importantes conséquences sur les plans pratique, juridique et éthique.

Les conséquences pratiques sont évidentes. Le don de tissus, d'organes ou de produits du corps humain peut de ce point de vue être fait de quatre façons : (1) à titre gratuit (le donneur ne reçoit pas d'argent du tout) ; (2) à titre onéreux (il reçoit une somme supérieure à ses frais) ; (3) avec remboursement des frais raisonnables (frais de déplacement, repas, hébergement, etc.) ; (4) avec remboursement des frais et des pertes de revenus,

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493. R.M. Titmuss, *op. cit.*, note 244, pp. 225-229 ; USTF, *op. cit.*, note 29, pp. 96, 98. Voir en général, *supra*, ch. II, section A(1).

494. Lloyd R. Cohen, « Increasing the Supply of Transplant Organs: The Virtues of a Futures Market » (1989), 58 *Geo. Wash. L. Rev.* 1, 2, 33 (l'auteur recommande le versement d'une somme de 5 000 $ à la succession du donneur/vendeur ou à une personne désignée par lui, lors du prélèvement d'organes effectué après le décès) ; Jack Kevorkian, « Marketing of Human Organs & Tissues is Justified and Necessary » (1989), 7:6 *Med. Law* 557.

495. R.D. Roberts et M.J. Wolkoff, *loc. cit.*, note 492.

496. Voir *supra*, pp. 67-70.

497. Voir M.J. Radin, *loc. cit.*, note 460, 1877-1887 (l'emploi du discours propre au marché favorise une conception de la personne qui est moralement inférieure). Voir également *supra*, pp. 67-70.

et versement d'une somme pour les douleurs et les souffrances. Quelles solutions ont été retenues dans la politique en vigueur et dans le droit actuel, au sujet de ces différents objectifs et de ces divers types de paiement ? Quelles solutions y aurait-il lieu de privilégier à l'avenir ?

Si la société décide qu'il est odieux que des personnes tirent un profit pécuniaire de l'échange de substances corporelles, devrait-elle carrément interdire tout paiement associé au processus du don ? Dans l'affirmative, la mise en œuvre de cette solution risque d'avoir, dans la pratique, des conséquences indésirables. Pour les personnes qui subissent un traitement médical impliquant de toute façon l'extraction de tissus susceptibles d'être greffés à une autre personne, le don de ces tissus ne cause aucun inconvénient véritable. Mais dans les autres cas, les donneurs sont obligés de consacrer temps et argent et de courir un risque médical pour réaliser leur intention charitable ou altruiste. La perte de revenus, les frais de déplacement et de repas peuvent alors, selon leur situation financière, constituer pour eux des obstacles tels qu'il leur est impossible dans la pratique de matérialiser leur intention charitable. La fréquence des dons ainsi que le temps et les déplacements nécessaires varient en fonction du tissu. Néanmoins, il y a lieu de croire, dans ces conditions, qu'une politique ou une loi interdisant carrément tout versement d'argent pourrait avoir un effet négatif en raison des frais inhérents au don, de la perte de revenu, de la douleur et de la souffrance et des risques médicaux souvent encourus par les donneurs.

Une autre approche, préconisée avec insistance par un groupe de travail fédéral sur les greffes d'organes, repose sur l'idée selon laquelle le don ne devrait entraîner pour le donneur ni gain ni perte sur le plan financier[498]. Cette approche présente des avantages et des inconvénients. D'une part, diront certains, elle s'écarte du principe du don charitable et gratuit, elle constitue une incitation financière et, à la limite, elle risque d'entraîner l'exploitation des plus démunis ; en outre, elle peut offenser et décourager ceux dont les intentions sont purement altruistes. En reconnaissant la légitimité d'une certaine contrepartie financière, la société pourrait par ailleurs être amenée à se demander ce qui constitue un paiement acceptable et raisonnable.

D'autre part, cette approche présente plusieurs avantages. Selon la façon dont sont définis les frais « raisonnables », elle contribue à l'élimination de certains obstacles financiers s'opposant aux dons. Les gens de toutes les couches de la société seraient placés sur un pied d'égalité quant à la possibilité de faire des dons de tissus et d'organes. En outre, le fait de rembourser les frais ne sape pas nécessairement le principe de l'altruisme — il pourrait même favoriser la pratique de cette vertu. Car le remboursement des frais raisonnables et de la perte de revenus ne dédommage pas le donneur des risques médicaux, de la douleur et de la souffrance volontairement assumés, qui demeurent une manifestation d'altruisme.

Enfin, cette approche peut contribuer à la préservation de l'altruisme dans la mesure où elle met l'accent sur le remboursement des frais raisonnables engagés au bénéfice

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498. FEDS, *op. cit.*, note 29, p. 65.

de la société, et non au paiement du tissu lui-même. Ces considérations ont convaincu les responsables dans plusieurs États. On a ainsi retenu la distinction entre vente et remboursement des frais raisonnables (ou l'on a recommandé son application) dans divers régimes : lois provinciales sur l'adoption et sur le don de tissus humains, lignes directrices nationales sur l'éthique en matière de recherche, textes américains et britanniques interdisant la vente d'organes, lignes directrices européennes sur le don de tissus humains et de sperme[499].

Une politique fondée sur le remboursement des frais raisonnables plutôt que sur le paiement du tissu lui-même a cependant des limites. À l'extrême, elle peut entraîner la constitution d'un marché de fait, susceptible de rendre illusoire toute distinction entre don et vente commerciale de tissus humains[500]. Pourtant, une telle distinction peut avoir d'autres conséquences juridiques importantes. Elle pourrait s'avérer utile dans les actions fondées sur une prétendue négligence au chapitre de l'examen préalable des tissus destinés à des greffes. De telles poursuites seraient sans doute tranchées en fonction des principes généraux applicables en matière de négligence ; il s'agirait donc de déterminer si la banque de tissus avait envers le receveur une obligation concernant l'examen des tissus et si elle a manqué à cette obligation, causant par le fait même la transmission d'une maladie[501]. Si l'on juge que la banque en question achète et vend des tissus humains, les principes juridiques régissant la vente de produits « défectueux » pourraient également être applicables[502]. Dans cette perspective, des tribunaux américains ont étudié la question de savoir si l'on devrait être plus sévère, sur le plan de la responsabilité civile, avec les banques de tissus qui se comportent plutôt comme des entreprises commerciales[503].

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499. Au sujet de l'application de cette distinction dans les lois sur l'adoption, voir *Re Female Infant*, précité, note 458 (interprétation du *Adoption Act* de la Colombie-Britannique, R.S.B.C. 1979, ch. 4, et des interdictions relatives à la vente des bébés) ; voir également *Loi de 1984 sur les services à l'enfance et à la famille*, L.O. 1984, ch. 55, art. 159 ; *Child Welfare Act*, R.S.O. 1980, ch. 66, art. 67. Dans le contexte de la recherche médicale, voir CRMC, *op. cit.*, note 118, p. 25 (« Il est moralement acceptable de dédommager le sujet d'une recherche pour rembourser les dépenses qu'il a dû faire et ses pertes raisonnables, y compris une perte de salaire, dans la mesure où cela n'empiète pas sur sa liberté de choix, mais facilite plutôt sa participation. De même, il est acceptable de verser une certaine somme, à condition qu'elle soit modique, en compensation du temps investi et des inconvénients subis. Une rémunération excessive ou d'autres avantages ou considérations constituent cependant des incitations inacceptables. »). Au sujet des lois provinciales sur le don de tissus humains, voir *infra*, pp. 155-158. Les législations américaine et européenne sont étudiées *infra*, au ch. IV.

500. Voir T.H. Murray, *loc. cit.*, note 351, 1074. Voir également *Baby M*, précité, note 457, 1247-1249.

501. Voir *Ravenis* c. *Detroit General Hospital*, 234 N.W. 2d 411 (Mich. App. 1975) (hôpital ayant fait preuve de négligence dans l'examen d'yeux prélevés sur des cadavres en vue de transplantations). Voir également *Zanne*, *infra*, note 951 et *Kitchen*, *infra*, note 1028.

502. Voir B.M. Dickens, *loc. cit.*, note 414, 195-197 ; l'auteur analyse l'affaire *Perlmutter* c. *Davis Hospital*, 123 N.E. 2d 792 (N.Y. 1954) (le donneur est rémunéré pour un service, et non pour le produit sanguin donné). Dans plusieurs États américains, on a établi cette distinction dans des textes législatifs où le prélèvement, le traitement et la distribution du sang et des tissus humains sont expressément désignés comme des services, et non comme une vente de produits. Voir *McKee* c. *Cutter Laboratories*, 866 F. 2d 219 (6th Cir. 1989). Les lois protègent les banques de tissus et les hôpitaux contre toutes poursuites fondées sur la vente de « produits défectueux ». Les banques peuvent néanmoins faire l'objet de poursuites pour négligence.

503. Voir *Gilmore*, précité, note 482, 1203-1207, et *Coffee* c. *Cutter Biological*, 809 F. 2d 191 (2nd Cir. 1987). Voir, d'une manière générale, les causes réunies dans Jay M. Zitter, « Liability of Blood Supplier or Donor for Injury or Death Resulting from Blood Transfusion », 24 A.L.R. 4th 508.

II. Droit pénal

Étant l'expression des valeurs fondamentales de la société et le régulateur de la conduite individuelle, le droit pénal offre également certaines pistes à l'égard de plusieurs problèmes relatifs au prélèvement et à l'aliénation de tissus humains[504]. Il précise certaines des obligations auxquelles sont assujettis les donneurs vivants et les professionnels des transplantations dans le cadre du traitement médical. Il joue depuis longtemps un rôle modeste mais notable en ce qui a trait à l'obtention, contre rémunération ou non, de cadavres à des fins médicales. En outre, même si les infractions de common law ont été en grande partie abolies au Canada en 1955[505], l'héritage de la common law en matière pénale exerce une influence subtile mais durable sur les notions de préjudice social et de mauvais traitements à l'égard des donneurs décédés. Au-delà de leur tradition et de leur évolution historique, les principes de droit pénal peuvent nous aider à préciser la situation, au regard du droit, des nouveau-nés anencéphales et des autres donneurs potentiels qui se trouvent à la frontière entre la vie et la mort.

Dans cette optique, le *Code criminel*[506] protège les droits et précise les devoirs et la responsabilité pénale dans trois domaines généraux relativement aux prélèvements et aux greffes de tissus : (1) les prélèvements sur des personnes vivantes ; (2) les prélèvements sur des personnes décédées ; (3) les critères juridiques de détermination de la mort, qui permettent de distinguer ces deux types de donneurs. Comment les dispositions du *Code criminel* sur les voies de fait[507], le traitement chirurgical et médical[508], les voies de fait causant des lésions corporelles[509], l'obligation de fournir les choses nécessaires à l'existence[510], la négligence criminelle[511] et l'homicide[512] s'appliquent-elles au don de tissus provenant de donneurs vivants et aux receveurs ? Permettent-elles un juste équilibre entre les valeurs sous-jacentes : promotion de l'autonomie de l'être humain, protection de l'intégrité du corps humain, préservation de la vie ? La Commission a déjà proposé des réformes d'un caractère général en ce qui concerne certaines de ces dispositions[513], et ces propositions s'avèrent utiles pour résoudre certaines ambiguïtés ou certains conflits apparents.

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504. Voir en général, Document de travail n° 26, *op. cit.*, note 370, pp. 5-6.

505. Voir *Code criminel*, L.R.C. (1985), ch. C-46, art. 8, 9.

506. *Ibid.* On trouvera à la section IV, *infra*, des observations sur les aspects pénaux des lois provinciales sur les tissus humains. Voir également Don STUART, *Canadian Criminal Law*, 2e éd., Toronto, Carswell, 1987, p. 2, où il est question des par. 92(14) et (15) de la *Loi constitutionnelle de 1867*, R.-U. 30 & 31 Vict., ch. 3 (autrefois désignée *Acte de l'Amérique du Nord britannique*, 1867), qui autorisent les provinces à infliger des amendes ou des peines d'emprisonnement en vue de l'application de lois provinciales, en raison de leur compétence en matière d'administration de la justice.

507. Voir *infra*, note 516.

508. Voir *infra*, le texte accompagnant la note 540, et les notes 560-562, *infra*.

509. Voir *infra*, le texte accompagnant les notes 516-519.

510. Voir *infra*, le texte accompagnant les notes 528-530.

511. Voir *infra*, le texte accompagnant les notes 560-564.

512. Voir le Document de travail n° 26, *op. cit.*, note 370, p. 39.

513. Voir en général, CRD, *L'omission, la négligence et la mise en danger*, Document de travail n° 46, Ottawa, la Commission, 1985 et Rapport n° 31, *op. cit.*, note 116.

S'agissant des donneurs décédés et de leur famille, quelle signification revêt de nos jours l'infraction, figurant au *Code criminel* et remontant au XVIII[e] siècle, qui consiste à commettre « tout outrage, indécence ou indignité envers un cadavre humain[514] » ? Le fait de vendre des parties du corps constitue-t-il une indignité ? Quelle est ou quelle devrait être l'incidence de cette disposition sur les interventions pratiquées sur des personnes cérébralement mortes et maintenues en vie par des moyens mécaniques, qui constituent la source la plus importante d'organes pour les transplantations ? Il s'agit là de questions qu'on n'a jamais eu à se poser auparavant, ce qui explique sans doute qu'on s'y soit très peu intéressé dans la littérature pénale canadienne. C'est pourquoi nous les étudierons ici, tout comme la façon dont, historiquement, c'est par le truchement du droit pénal qu'on a permis à la médecine de se procurer les cadavres dont elle avait besoin.

La définition de la mort revêt bien sûr ici une grande importance. Si le donneur est en vie, les dispositions du droit pénal régissant le prélèvement d'organes sur des personnes vivantes peuvent s'appliquer. S'il est mort, ce sont les dispositions relatives aux outrages à l'égard d'un cadavre qui pourront être applicables. D'aucuns demandent que la définition de la mort soit modifiée, pour faciliter le prélèvement d'organes sur une certaine catégorie de nouveau-nés mourants ; cela oblige la Commission à réexaminer la recommandation qu'elle a faite il y a une dizaine d'années sur les critères de détermination de la mort cérébrale. Ayant passé les considérations médicales et éthiques pertinentes au crible des principes et des grandes orientations sur lesquels la Commission avait fondé sa recommandation initiale, nous sommes convaincus qu'il y a lieu de rejeter les demandes visant la modification des critères en question.

A. Donneurs vivants et receveurs

Le droit pénal assujettit à un critère fondé sur la notion de bienfaisance certaines transplantations et greffes ; c'est-à-dire que les bienfaits procurés par le don et la greffe ou la transplantation ne doivent pas être disproportionnés aux préjudices causés par ailleurs[515]. En assujettissant au respect de ce critère les procédures touchant le consentement, le processus du don ainsi que les interventions chirurgicales, le droit pénal protège et favorise l'intégrité du corps humain, la préservation de la vie et l'autonomie de l'être humain.

(1) Droits et obligations du donneur

Le souci de l'intégrité corporelle et de la valeur de la vie se manifeste dans les obligations imposées au donneur vivant. Si les dispositions du *Code criminel* concernant

514. Voir *infra*, le texte accompagnant la note 675.

515. Voir le Document de travail n° 46, *op. cit.*, note 513, p. 6. Voir également le Rapport n° 31, *op. cit.*, note 116, p. 71.

les voies de fait[516] donnent effet à la règle de common law et aux principes moraux suivant lesquels toute atteinte à l'intégrité corporelle d'une personne doit être autorisée par celle-ci, d'autres considérations juridiques contribuent à préciser les règles actuelles relatives au don de tissus humains. Au Canada, par exemple, la récente condamnation au criminel, pour nuisance publique, d'une personne ayant sciemment donné du sang alors qu'elle se savait porteuse du VIH souligne le souci des autorités de protéger la vie, la santé et la sécurité des citoyens[517]. En revanche, les dispositions du *Code criminel* interdisant à quiconque de consentir à la mort[518] et de mutiler une personne ou de lui causer illégalement des lésions corporelles[519] témoignent de la volonté de protéger l'autonomie, la santé et l'intégrité corporelle des donneurs comme des receveurs, en définissant les limites du consentement d'une personne à une atteinte à son intégrité corporelle. Les conséquences de l'interdiction de consentir à la mort sont évidentes :

> [TRADUCTION]
> Ce principe empêcherait donc une personne de donner par altruisme son foie ou un autre organe sans lequel elle ne peut vivre[520].

Par ailleurs, les conséquences pratiques de l'interdiction de mutiler une personne et de lui causer illégalement des lésions corporelles se sont toujours avérées plus nébuleuses dans le contexte des interventions chirurgicales. Cette interdiction découle du crime appelé en anglais « mayhem », qui remonte au Moyen Âge et consiste dans le fait de causer l'incapacité permanente d'une personne ou son affaiblissement[521]. On a pu faire valoir que la règle ne saurait être étendue aux transplantations d'organes, en raison de leurs

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516. L'art. 265 du *Code criminel* énonce : « Commet des voies de fait, [. . .] quiconque, [. . .] *a*) d'une manière intentionnelle, emploie la force, directement ou indirectement, contre une autre personne sans son consentement [. . .] ». Voir également le Rapport n° 31, *op. cit.*, note 116, pp. 70-72. Pour une affaire récente portant sur une condamnation pour voies de fait suite à des examens rectaux non autorisés pratiqués sur des déficients mentaux internés, voir *R.* c. *Wiens* (22 juin 1985), (C. Prov. Ont.) (décision non publiée), commentée dans Harvey SAVAGE et Carla MCKAGUE, *Mental Health Law in Canada*, Toronto, Butterworths, 1987, pp. 202-203. Cette affaire montre par ailleurs qu'en protégeant l'intégrité corporelle, les règles touchant le consentement protègent également des droits fondamentaux rattachés par exemple à la dignité humaine et à la vie privée.

517. *R.* c. *Thornton* (1991), 1 O.R. (3e) 481 (C.A.). Voir aussi Tonda MACCHARLES, « Conviction Stuns AIDS Blood Donor », *The [Ottawa] Citizen* (16 juin 1989) A1 (il est question dans cet article de la possibilité de porter des accusations de négligence criminelle et de méfait public dans de telles circonstances). Voici le libellé de la disposition du *Code criminel* sur la nuisance publique (art. 180) :

> Est coupable d'un acte criminel et passible d'un emprisonnement maximal de deux ans quiconque commet une nuisance publique, et par là, selon le cas :
> *a*) met en danger la vie, la sécurité ou la santé du public ;
> *b*) cause une lésion physique à quelqu'un.

518. *Code criminel*, art. 14 :

> Nul n'a le droit de consentir à ce que la mort lui soit infligée, et un tel consentement n'atteint pas la responsabilité pénale d'une personne par qui la mort peut être infligée à celui qui a donné ce consentement.

519. Voir l'art. 269 du *Code criminel* ; *Daigle* c. *La Reine*, [1987] R.J.Q. 2374, 2380-2381 (C.A.) ; *R.* c. *Innes* (1972), 7 C.C.C. (2e) 544 (C.A. C.-B.). Voir également le Rapport n° 31, *op. cit.*, note 116, p. 71.

520. J.K. MASON et R.A. MCCALL SMITH, *Law and Medical Ethics*, 2e éd., Londres, Butterworths, 1987, p. 221.

521. R. SCOTT, *op. cit.*, note 268, p. 63 ; *R.* c. *Innes*, précité, note 519, 547, 548.

avantages sociaux importants[522]. Ces avantages justifient-il qu'une personne donne un rein à un receveur — apparenté ou non — quand on sait qu'environ vingt donneurs sont décédés suite au prélèvement d'un rein pratiqué, en vue d'une transplantation, dans des établissements reconnus[523] ? D'autres prétendent que l'interdiction de tels dons serait démesurément paternaliste, qu'elle priverait certains donneurs du privilège de faire preuve d'altruisme et qu'elle s'opposerait à l'intérêt public, vu le problème de la pénurie d'organes[524]. Ces considérations donnent à penser que la nécessité publique justifie d'une manière générale la pratique en cause, la légitime et supprime tout risque d'une accusation de mutilation ou d'infliction illégale de lésions corporelles[525]. Par contre, certaines craintes ayant trait aux atteintes possibles à l'intégrité corporelle du donneur, à l'exploitation des personnes vulnérables et la vente d'organes ont entraîné des propositions visant à interdire de tels dons, sauf dans des circonstances limitées et strictement réglementées[526]. Dans la plupart des centres de transplantation, on préfère encore éviter d'avoir recours à des donneurs vivants non apparentés[527].

Les préoccupations relatives à l'intégrité du corps humain, à la préservation de la vie et à l'équilibre entre les risques et les avantages se mêlent aux considérations juridiques relatives à l'obligation de faire un don. Existe-t-il des circonstances dans lesquelles le droit pénal impose une obligation de faire un don ? Le *Code criminel* oblige les époux ou les parents à fournir « les choses nécessaires à l'existence » à leur conjoint ou à leur enfant[528]. Le défaut, sans excuse légitime, de fournir des choses nécessaires à l'existence, comme des injections d'insuline ou des transfusions sanguines, peut donc constituer une infraction

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522. Voir Note, « The Sale of Human Body Parts » (1974), 72 *Mich. L. Rev.* 1182, 1240.

523. Thomas E. STARZL, « Will Live Organ Donations No Longer Be Justified? » (1985), 15:2 *Hast. Cent. Rep.* 5.

524. Voir Martyn EVANS, « Organ Donations Should Not Be Restricted to Relatives » (1989), 15:1 *J. Med. Ethics* 17.

525. Voir J.K. MASON et R.A. MCCALL SMITH, *op. cit.*, note 520, p. 221. Voir également l'art. 45 du *Code criminel*, dont il est question dans le texte accompagnant la note 540, *infra* ; Rapport n° 31, *op. cit.*, note 116.

526. Voir le *Human Organ Transplants Act 1989*, (R.-U.) 1989, ch. 31, analysé, *infra*, au ch. IV.

527. Voir LEVY et autres, « Kidney Transplantation from Unrelated Living Donors » (1986), 314:14 *N. Engl. J. Med.* 914, 915 ; M. EVANS, *loc. cit.*, note 524.

528. L'article 215 du *Code criminel* dispose notamment :

> (1) *Toute personne est légalement tenue* :
>
> *a*) *en qualité de père ou mère*, de parent nourricier, de tuteur ou de chef de famille, de fournir les choses nécessaires à l'existence d'un enfant de moins de seize ans ;
>
> *b*) *à titre de personne mariée*, de fournir les choses nécessaires à l'existence de son conjoint ;
>
> *c*) *de fournir les choses nécessaires à l'existence d'une personne à charge, si cette personne est incapable, à la fois* :
>
> (i) par suite de détention, d'âge, de maladie, d'aliénation mentale ou pour une autre cause, de se soustraire à cette charge,
>
> (ii) de pourvoir aux choses nécessaires à sa propre existence.
>
> (2) *Commet une infraction quiconque, ayant une obligation légale* au sens du paragraphe (1), *omet, sans excuse légitime*, dont la preuve lui incombe, *de remplir cette obligation, si* :

criminelle[529]. La Commission a étendu la portée de ces principes en faisant une proposition selon laquelle chacun serait tenu de prendre les « mesures raisonnables afin de porter assistance » à une personne qui semble « exposée à un risque immédiat de mort ou de préjudice corporel grave[530] ». Une telle obligation figure dans les codes pénaux de la Belgique, de la France, de la Grèce et du Vermont ; elle vise certaines situations classiques, comme celle où une personne, manifestement en train de se noyer, ne reçoit aucune aide ni assistance de compagnons qui seraient en mesure de l'aider sans mettre en péril leur propre sécurité[531]. Il n'y a cependant pas d'obligation lorsque le sauvetage entraîne des risques de préjudice grave pour le sauveteur potentiel ou lorsque ce dernier a d'autres raisons valables de s'abstenir[532].

L'application de ces principes au don de tissus humains amènerait sans doute à conclure que le don d'organes est rarement exigé par la loi, qu'il ne l'est peut-être même jamais. Il n'existe dans la jurisprudence canadienne publiée aucune décision portant spécifiquement sur cette obligation. Cinq décisions nord-américaines relatives au don de moelle osseuse, qui ne relèvent pas du droit pénal, font bien ressortir la complexité du problème. Dans l'une de ces affaires, un homme souffrant d'anémie aplastique demandait au tribunal d'ordonner à son cousin germain, le seul donneur compatible qu'on avait pu trouver, à donner de sa moelle osseuse. Sans la transplantation, le malade n'avait pas beaucoup de chances de s'en tirer. Or le tribunal, malgré l'urgence de la situation, a refusé de rendre une telle ordonnance pour le motif que le fait de prélever des tissus sur le cousin contre

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a) à l'égard d'une obligation imposée par l'alinéa (1)*a*) ou *b*) :
(i) ou bien la personne envers laquelle l'obligation doit être remplie se trouve dans le dénuement ou dans le besoin,
(ii) ou bien *l'omission de remplir l'obligation met en danger la vie de la personne envers laquelle cette obligation doit être remplie, ou expose, ou est de nature à exposer, à un péril permanent la santé de cette personne* ;

b) à l'égard d'une obligation imposée par l'alinéa (1)*c*), l'omission de remplir l'obligation *met en danger la vie* de la personne envers laquelle cette obligation doit être remplie, ou cause, ou est de nature à causer, un tort permanent à la santé de cette personne.

(3) Quiconque commet une infraction visée au paragraphe (2) est coupable :

a) soit d'un acte criminel et passible d'un emprisonnement maximal de deux ans ;

b) soit d'une infraction punissable sur déclaration de culpabilité par procédure sommaire.
[Mis en italiques par nos soins].

529. Comparer *R.* c. *Tutton*, [1989] 1 R.C.S. 1392 (des parents qui, pour des motifs religieux, refusent délibérément de donner des injections d'insuline à leur enfant diabétique de 5 ans peuvent être accusés de négligence criminelle ayant causé la mort, pour avoir négligé sans excuse légitime de fournir les choses nécessaires à l'existence) et *R.* c. *Cyrenne* (1981), 62 C.C.C. (2e) 238 (C. distr. Ont.) (le tribunal a conclu que les parents n'étaient pas coupables de négligence criminelle, car on n'avait pas établi hors de tout doute raisonnable que la mort avait été causée par l'absence de transfusion sanguine). Voir également *R.* c. *Lewis*, *infra*, note 909.

530. Voir Rapport n° 31, *op. cit.*, note 116, p. 77, par. 10(2) (« *a*) Règle générale. Commet un crime quiconque, s'apercevant qu'une autre personne est exposée à un risque immédiat de mort ou de préjudice corporel grave, ne prend pas des mesures raisonnables afin de lui porter assistance. *b*) Exception. L'alinéa 10(2)*a*) ne s'applique pas lorsque la personne ne peut pas intervenir sans risque de mort ou de préjudice corporel grave pour elle-même ou pour autrui, ou lorsqu'elle a une autre raison valable de ne pas intervenir. »). Voir également, Document de travail n° 46, *op. cit.*, note 513, pp. 18-22.

531. *Ibid.* Voir également Clare Elaine RADCLIFFE, « A Duty to Rescue: The Good, the Bad and the Indifferent — The Bystanders' Dilemma » (1986), 13 *Pepperdine L. Rev.* 387. Thomas C. GREY, *The Legal Enforcement of Morality*, New York, Alfred A. Knopf, 1983, pp. 157-197.

532. Rapport n° 31, *op. cit.*, note 116, p. 77.

son gré constituerait une atteinte à l'autonomie de sa volonté et à son intégrité corporelle[533]. Le patient est décédé peu de temps après. Cette affaire semble avoir été tranchée en fonction de l'autonomie de l'être humain, mais les risques associés à la transplantation de la moelle osseuse[534] pourraient être perçus comme un « risque de préjudice grave » ou pourraient constituer par ailleurs une excuse légitime suffisante pour soustraire une personne à l'obligation du don. Dans le cas de tissus dont le prélèvement entraîne une atteinte moins grave à l'intégrité corporelle et des risques médicaux moins grands pour le donneur, les préoccupations relatives au risque de préjudice grave semblent toutefois moins convaincantes.

Quatre autres affaires soulèvent la question de savoir ce qui peut être visé par l'obligation de prendre des mesures raisonnables, indépendamment du don de moelle en tant que tel. Récemment, un tribunal américain a rejeté une requête par laquelle on lui demandait d'ordonner que des jumeaux âgés de trois ans se soumettent à des analyses en vue d'un éventuel don de moelle osseuse à un demi-frère[535]. Le tribunal avait été saisi de l'affaire parce que les parents des jumeaux, qui étaient séparés (la mère ayant la garde) n'étaient pas d'accord sur l'opportunité de faire subir aux enfants les analyses de sang qui permettraient de savoir si l'on pouvait envisager une greffe de moelle osseuse à leur demi-frère mourant âgé de treize ans, qu'ils n'avaient jamais vu. Dans une affaire antérieure, un cancéreux voulait forcer un centre de transplantation à lui communiquer certains renseignements et à prendre les mesures nécessaires afin de prélever la moelle de M^me^ X, qui semblait compatible avec la sienne[536]. Le tribunal a refusé d'accéder à cette requête. Il a conclu que les renseignements contenus dans l'ordinateur du centre constituaient des dossiers médicaux confidentiels auxquels le malade en question n'avait aucun droit d'accès

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533. *McFall* c. *Shimp*, 10 Pa. D. & C. 3d 90 (Allegheny Cnty Ct 1978) ; Case Comment, « Coerced Donation of Body Tissues: Can We Live with *McFall* v. *Shimp* » (1979), 40 *Ohio St. L.J.* 409 ; Alan MEISEL et Loren H. ROTH, « Must A Man Be His Cousin's Keeper? » (1978), 8:5 *Hast. Cent. Rep.* 5. Voir *supra*, ch. II, section III.

534. Les risques associés à la transplantation de la moelle osseuse ont récemment été résumés ainsi :

> [TRADUCTION]
> Le prélèvement exige une hospitalisation. Il se fait sous rachianesthésie ou sous anesthésie générale, avec peu de morbidité sinon une douleur légère ou sévère pendant plusieurs jours à l'endroit où l'aspiration a été faite. Des complications mettant la vie en danger ne sont survenues que dans 9 des 3 290 interventions signalées, soit un taux de 0,027 %. Parmi ces complications, on peut citer les suivantes : arrêt non fatal des fonctions cardiaques, embolie pulmonaire, pneumonie découlant de l'aspiration, tachycardie ventriculaire, infarctus cérébral. On a signalé la mort d'un donneur résultant d'un arrêt cardiaque survenu durant la mise sous anesthésie générale. Le don de moelle osseuse a aussi eu, à l'occasion, d'autres conséquences fâcheuses : hémorragie nécessitant des transfusions sanguines, un cas de bris de l'aiguille d'aspiration, ayant nécessité une intervention chirurgicale, et quelques épisodes d'hypotension, d'arythmie auriculaire et de laryngospasmes.
>
> U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, PUBLIC HEALTH SERVICE, NATIONAL CENTER for HEALTH SERVICES RESEARCH and HEALTH CARE TECHNOLOGY ASSESSMENT, *Reassessment of Autologous Bone Marrow Transplantation*, Washington (D.C.), U.S. Government Printing Office, 1988, p. 2.

535. *Curran* c. *Bosze*, 566 N.E. 2d 1319 (Ill. 1990).

536. *Head* c. *Colloton*, 331 N.W. 2d 870 (Iowa 1983) ; « Mrs. X and the Bone Marrow Transplant » (1983), 13:1 *Hast. Cent. Rep.* 17.

particulier[537]. Dans d'autres affaires où des personnes atteintes de leucémie voulaient se faire donner l'accès à des dossiers confidentiels, les tribunaux ont tantôt accueilli, tantôt rejeté la demande. Un tribunal du Québec a fait droit à la requête d'un enfant qui voulait consulter des registres d'adoption confidentiels simplement pour déterminer si ses parents biologiques étaient des donneurs potentiels de moelle osseuse[538]. Une requête similaire a par contre été rejetée par un tribunal américain[539].

D'aucuns jugeront impitoyables les décisions rendues dans la plupart de ces affaires. Les lois en vigueur là où les tribunaux ont rejeté la requête ne reconnaissaient pas, en général, l'existence d'une obligation de porter secours. Ces décisions, à tout le moins, contribuent à montrer que, outre les préoccupations relatives à l'intégrité physique des donneurs potentiels, les principes du respect de la vie privée et de la confidentialité doivent être pris en compte lorsqu'on s'interroge sur l'existence d'une quelconque obligation de don. Dans les États où l'on souhaite imposer une obligation raisonnable de secours tout en respectant la confidentialité, on pourrait, comme l'a fait le tribunal québécois, exiger que des tentatives soient faites pour entrer en contact avec des donneurs potentiels, étant toutefois entendu que l'identité des personnes en cause ne doit pas être révélée.

(2) Préjudice et bienfait raisonnable

De façon générale, le *Code criminel* protège de la responsabilité pénale le médecin qui effectue une transplantation d'organe présentant un avantage raisonnable pour le patient :

> Toute personne est à l'abri de responsabilité pénale lorsqu'elle pratique sur une autre, *pour le bien de cette dernière*, une opération chirurgicale si, à la fois :
>
> *a*) l'opération est pratiquée avec des soins et une habileté raisonnables ;
>
> *b*) *il est raisonnable* de pratiquer l'opération, étant donné l'état de santé de la personne au moment de l'opération et toutes les autres circonstances de l'espèce[540].

Comment est-il possible de concilier la disposition portant que la transplantation chirurgicale doit être pratiquée pour le bien du patient, et le fait que le don de sang, de moelle osseuse ou d'un rein n'apporte aucun avantage physique au donneur ? Premièrement, la disposition s'applique aux opérations chirurgicales, et ne semble donc pas viser le don de sang ou de substances semblables qui est, en général, considéré comme un acte médical. Deuxièmement, si la disposition peut de prime abord sembler exclure les transplantations de tissus et d'organes entre les membres d'une même famille, un certain nombre d'approches ont été proposées pour résoudre cette difficulté.

L'une de ces approches consiste à interpréter largement l'expression « le bien du patient », de manière à y englober les bienfaits psychologiques qu'est présumé recevoir le donneur dans le cas d'une transplantation d'organes effectuée pour soigner un membre

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537. *Head* c. *Colloton*, précité, note 536.

538. *Droit de la famille — 140*, [1984] 2 R.J.Q. 2049 (T.J.).

539. *Application of George*, 630 S.W. 2d 614 (Mo. App. 1982).

540. *Code criminel*, art. 45 [mis en italiques par nos soins].

de sa famille[541]. L'application de cette théorie, cependant, pourrait être limitée dans les cas où les présumés bienfaits psychologiques semblent moindres, par exemple lorsque le don est fait en faveur de personnes qui ne sont pas apparentées au donneur. Des auteurs remettent en outre en question la validité de cette théorie elle-même[542]. Une autre approche consiste à présumer l'existence d'un bienfait pour le donneur lorsqu'il a donné son consentement[543]. On estime alors que le *Code criminel* est fondé sur le principe de la protection des personnes, et qu'il est raisonnable de présumer que celui qui donne son consentement veille à sa propre protection et recherche son propre bien[544]. La Commission de réforme du droit a adopté ce point de vue[545], estimant que les dispositions du *Code criminel* où sont définis des crimes contre l'intégrité corporelle[546] ne devraient pas être applicables au prélèvement de tissus et d'organes effectué après l'obtention d'un consentement éclairé, pourvu que les risques soient proportionnés aux avantages espérés. Comme on ne semble pas avoir prévu au Code les cas où de tels prélèvements sont effectués pour le bien d'une autre personne, il serait opportun de faire les modifications législatives appropriées[547]. L'obligation pour le médecin d'informer l'intéressé des risques serait d'autant plus grande, du point de vue de la validité du consentement, que les bienfaits tirés par lui tendent à être de nature non thérapeutique[548].

Ni l'une ni l'autre de ces approches n'offre une solution évidente en ce qui a trait aux problèmes complexes que suscite le don d'organe fait par des mineurs et des personnes atteintes de déficience mentale[549]. Le cas du mineur ayant la faculté[550] de comprendre et d'apprécier les risques, les bienfaits et les conséquences du don d'un organe à son frère ou à sa sœur semble assimilable à celui d'un adulte placé dans les mêmes circonstances. Parce qu'elle comporte de profondes conséquences émotionnelles, la décision de donner ou de refuser son consentement est délicate et douloureuse même pour un adulte[551].

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541. Voir, *supra*, les décisions commentées à la section II.B, ch. II. Voir également le Document de travail n° 26, *op. cit.*, note 370, p. 66.

542. Voir par exemple, Margaret A. SOMERVILLE, « Medical Interventions and the Criminal Law: Lawful or Excusable Wounding » (1980-1981), 26 *R.D. McGill* 82, 88, n. 16.

543. Voir *id.*, 92. Voir également Bernard STARKMAN, « A Defence to Criminal Responsibility for Performing Surgical Operations: Section 45 of the *Criminal Code* » (1980-1981), 26 *R.D. McGill* 1048.

544. Document de travail n° 26, *op. cit.*, note 370, pp. 67-68.

545. Voir Rapport n° 31, *op. cit.*, note 116, p. 72 et Document de travail n° 61, *op. cit.*, note 295. Voir également CRMC, *op. cit.*, note 118, pp. 13, 21.

546. Voir *supra*, section II.A(1).

547. Voir Document de travail n° 61, *op. cit.*, note 295, p. 39 ; Rapport n° 31, *op. cit.*, note 116, p. 72.

548. Voir *Halushka*, précité, note 376.

549. Voir en général Bernard STARKMAN, « *Inter Vivos* Transplantation: The Child and Dependent Adult as Donors » (1985), 17:6 (Suppl. 4) *Transplant. Proc.* 40.

550. Le problème de la capacité des mineurs de prendre une telle décision est traité dans Margaret A. SOMERVILLE, « Refusal of Medical Treatment in "Captive" Circumstances » (1985), 63 *R. du B. can.* 59.

551. Voir John E. THOMAS, « Am I My Brother's Keeper? » (oct. 1987), *Can. Doctor* GP8. On trouvera des considérations générales sur cette question dans George THOMSON, « Minors and Medical Consent » (1981), 2:4 *Health L. Can.* ; W.F. BOWKER, *loc. cit.*, note 378, 969.

Dans le cas des donneurs potentiels que l'on juge incapables de donner un consentement et donc de veiller à leur propre protection, les « bienfaits » nets du don peuvent justifier la transplantation dans des circonstances exceptionnelles, pour des motifs tenant à la nécessité[552]. À l'aune des principes éthiques de la bienfaisance et de la non-malfaisance[553], les dons d'organe qui ne comportent aucun risque grave tout en étant susceptibles d'apporter des bienfaits psychologiques au donneur et de sauver la vie du receveur, pourraient être justifiables. Le principe de bienfaisance, qui exige que le risque de préjudice ne soit pas hors de proportion avec les bienfaits espérés, est davantage susceptible d'être respecté si l'on accepte seulement les dons entre membres d'une même famille. Ainsi, le don de moelle osseuse d'un enfant mineur à son frère pourrait être jugé conforme à la fois à l'éthique, à l'ordre public et à la loi[554]. Toutefois, plus l'atteinte à l'intégrité corporelle, l'irréversibilité et les risques associés au prélèvement sont élevés — on peut citer le cas des transplantations rénales —, plus augmentent les préoccupations relatives à l'intégrité physique du donneur, qui qu'il soit. Si l'on tient à ce que les donneurs dépourvus de la capacité de consentir soient protégés contre les risques de préjudice et à ce que leur vulnérabilité particulière ne soit pas exploitée, il serait sans doute préférable d'envisager le don seulement après qu'ont été épuisées toutes les autres solutions médicales raisonnables, et uniquement si l'on a obtenu le consentement du tuteur. Pour respecter pleinement la volonté des donneurs potentiels, il y aurait lieu de chercher à obtenir leur consentement et à respecter un éventuel refus. Ces considérations ont incité des organismes étrangers, notamment la Commission de réforme du droit de l'Australie[555] et le Conseil de l'Europe[556], à ne permettre les dons d'organes de personnes incapables que dans des circonstances bien précises, semblables à celles qui viennent d'être évoquées. Par ailleurs,

552. Voir Rapport n° 31, *op. cit.*, note 116, p. 72 ; Document de travail n° 26, *op. cit.*, note 370, pp. 68-69.

553. Voir *supra*, note 283 et *infra*, section II.B.

554. Voir, par exemple, *Cayouette et Mathieu*, précité, note 380. Même s'il n'y avait dans cette affaire aucun aspect pénal, la décision donne à entendre que les transplantations dont le donneur ne retire aucun bienfait sur le plan physique peuvent néanmoins être conformes à l'ordre public et au droit pénal, ainsi qu'aux principes éthiques de la nécessité et de la bienfaisance. Voir Document de travail n° 26, *op. cit.*, note 370, p. 66.

555. Voir COMMISSION DE RÉFORME DU DROIT DE L'AUSTRALIE, *infra*, note 1010, pp. 50-51 (la commission a recommandé : (1) que le don de tissus susceptibles de régénération fait par un mineur soit tenu pour légal, pourvu que le mineur soit sain d'esprit, qu'il consente au don, que le père ou la mère y consente et qu'on obtienne une opinion médicale indépendante ; (2) que le don de tissus non susceptibles de régénération soit généralement interdit, sauf lorsque les conditions suivantes sont remplies : le donneur et le receveur sont membres de la même famille, une opinion médicale indépendante a été obtenue sur la nature et les conséquences du don et de la transplantation, les parents ont consenti par écrit, le donneur a des capacités intellectuelles suffisantes et consent au don, auquel consent également de manière unanime un comité indépendant ; (3) qu'il soit illégal de prélever des tissus sur les personnes atteintes de déficience mentale.).

556. Voir CONSEIL DE L'EUROPE, Texte final, *infra*, note 965, p. 276 (on a recommandé l'adoption d'une règle générale interdisant les prélèvements sur une personne « frappée d'incapacité juridique », deux exceptions étant prévues : (1) le prélèvement concerne des tissus susceptibles de régénération, il est justifié sur le plan thérapeutique pour le receveur, le représentant juridique y consent, ainsi que le donneur lui-même s'il en a la capacité (art. 10) ; (2) le prélèvement d'un rein, lorsque les conditions suivantes sont remplies : il n'est pas « possible » de recourir à la dialyse et aucun rein prélevé sur un donneur décédé n'est « disponible » ; le donneur et le receveur sont « étroitement apparentés génétiquement » ; le représentant légal du donneur et les autorités compétentes y consentent, ainsi que le donneur lui-même s'il a la capacité de le faire (art. 8 et 10). Cette recommandation s'oppose d'une manière générale au prélèvement lorsqu'il « présente un risque sérieux et prévisible pour la vie, la santé ou l'activité fonctionnelle du donneur » (art. 13)).

la Conférence sur l'uniformisation des lois au Canada a, plus récemment, recommandé pour sa part qu'une « évaluation indépendante » soit exigée dans le cas de tout don de tissus non susceptibles de régénération, et de tout don de tissus fait par des personnes âgés de moins de seize ans[557]. La recommandation de la Commission de réforme du droit du Canada selon laquelle les décisions relatives à ces interventions doivent être prises en fonction des circonstances de chaque cas particulier semblerait conforme à la solution retenue par la Conférence[558]. Même lorsque le don d'un rein par un mineur incapable semble se justifier du point de vue éthique par la règle de la bienfaisance et que toute poursuite pénale est exclue à cause de l'argument de la nécessité, certaines préoccupations récemment exprimées par la Cour suprême du Canada jettent un autre éclairage sur la question de savoir si des interventions médicales portant irréversiblement atteinte à l'intégrité corporelle d'une personne au profit d'une autre sont légalement justifiées[559].

(3) Compétence médicale

Enfin, le droit pénal protège l'intégrité corporelle des donneurs et des receveurs en exigeant que les professionnels de la santé qui effectuent les transplantations et les actes médicaux connexes aient les connaissances et la compétence requises, et y mettent tout le soin voulu[560]. En outre, les interventions chirurgicales ou médicales ne doivent pas être pratiquées avec une « insouciance déréglée ou téméraire » à l'égard de la santé ou de la sécurité[561]. Le fait de passer outre à ces exigences expose en théorie le médecin à des accusations de négligence criminelle lorsque cette négligence entraîne des lésions corporelles ou la mort.

En pratique toutefois, une faute professionnelle n'entraîne que rarement la responsabilité pénale des professionnels de la santé[562]. Dans la plupart des cas, le patient lésé

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557. Voir le texte accompagnant la note 834, *infra*.

558. Voir Document de travail n° 26, *op. cit.*, note 370, pp. 68-69. Voir également *Loi uniforme sur le don de tissus humains* (1989), art. 6 et 7, commentés *infra*, note 833 et suiv. Ces dispositions prévoient ce qui suit : (1) une personne âgée de moins de 16 ans ne peut faire un don que si les résultats d'une évaluation indépendante indiquent qu'il y a lieu d'y procéder (par. 6(4)) ; (2) les tissus prélevés sont susceptibles de régénération (par. 6(1)) ; (3) le mineur comprend la nature et les effets de la transplantation — une exception est établie pour le don de moelle osseuse à un frère ou une sœur biologique mineur, auquel peut consentir le tuteur légal au nom du mineur.

559. Voir la décision *Eve*, commentée dans le texte accompagnant la note 362, *supra*.

560. Article 266 du *Code criminel* :

> Quiconque entreprend d'administrer un traitement chirurgical ou médical à une autre personne ou d'accomplir un autre acte légitime qui peut mettre en danger la vie d'une autre personne est, sauf dans les cas de nécessité, légalement tenu d'apporter, en ce faisant, une connaissance, une habileté et des soins raisonnables.

Voir également l'art. 45, cité dans le texte qui accompagne la note 540, *supra*.

561. *Id.*, art. 219, 220.

562. Document de travail n° 26, *op. cit.*, note 370, pp. 1, 55. Voir également Ellen I. PICARD, *Legal Liability of Doctors and Hospitals in Canada*, 1re éd., Toronto, Carswell, 1978, pp. 298, 300. Comparer *Wiens*, précité, note 516 et *R.* c. *Sullivan*, [1991] 1 R.C.S. 489 (acquittement d'une sage-femme accusée de négligence criminelle).

engage des poursuites au civil contre l'hôpital ou le médecin[563]. Dans les rares cas où la faute médicale donne ouverture à des poursuites pénales, la conduite est jugée selon une norme qui diffère de celle applicable aux litiges civils. Généralement, la négligence criminelle exige un « écart marqué[564] » par rapport à la norme générale de la diligence raisonnable. Il pourrait s'agir, en théorie, d'écarts marqués par rapport aux pratiques médicales jugées acceptables pour déterminer la mort cérébrale[565] et à d'autres aspects du processus de la transplantation.

B. Donneurs vivants ou décédés : les nouveau-nés anencéphales

En 1981, la Commission de réforme du droit du Canada proposait l'application du critère de la « cessation irréversible de l'ensemble [des] fonctions cérébrales » pour la détermination de la mort, pour toutes les fins qui sont de la compétence du Parlement du Canada, et notamment pour l'application du *Code criminel*[566]. L'évolution des dernières années a poussé certaines personnes à réclamer que l'on apporte des modifications à ce critère, ou que l'on exclue de son application certains patients nés dans un état « incompatible avec la vie », à savoir les nouveau-nés anencéphales. La proposition met en cause, sous deux aspects généraux, la politique pénale et les principes qui la concrétisent. Premièrement, si le nouveau-né anencéphale n'est pas décédé, diverses dispositions de droit pénal s'appliquent, qui ont trait aux donneurs vivants et aux receveurs — obligation d'administrer un traitement médical, devoir de fournir les choses nécessaires à l'existence, négligence criminelle, fait de hâter la mort, homicide, etc.[567]. Si les anencéphales nés

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563. Voir en général E.I. PICARD, *op. cit.*, note 364.

564. Rapport n° 31, *op. cit.*, note 116, p. 27. La Cour suprême du Canada reste divisée sur la question de savoir si la négligence criminelle devrait être déterminée au regard d'une norme objective (personne raisonnable) ou d'une norme plus subjective. Voir *R.* c. *Waite*, [1989] 1 R.C.S. 1436. Voir également *Tutton*, précité, note 529. Voir en général D. STUART, *op. cit.*, note 506, pp. 183-198.

565. Voir *People* c. *Eulo*, 472 N.E. 2d 286, 297 (N.Y. 1984) ([TRADUCTION] « Toutefois, si les déclarations de décès étaient prématurées en raison d'une négligence grave des médecins ou d'une faute intentionnelle de leur part, consistant dans un écart sérieux par rapport aux pratiques médicales acceptées ou dans l'inobservation des critères applicables en droit pour la détermination de la mort, les interventions médicales pratiquées [...] deviendraient la cause du décès en droit »). Comparer *R.* c. *Kitching* (1976), 32 C.C.C. (2e) 159 (C.A. Man.) (le tribunal a adapté la définition de la mort cérébrale, en concluant que le prélèvement d'organes sur un patient cérébralement mort, qui avait subi des voies de fait criminelles, n'avait pas été la cause du décès).

566. Rapport n° 15, *op. cit.*, note 1, pp. 27-28. (« Pour toutes les fins qui sont de la compétence du Parlement du Canada : (1) une personne décède au moment où elle subit une cessation irréversible de l'ensemble de ses fonctions cérébrales. (2) la cessation irréversible des fonctions cérébrales peut être constatée à partir de l'absence prolongée de fonctions circulatoire et respiratoire spontanées. (3) lorsque l'utilisation de mécanismes de soutien rend impossible la constatation de l'absence prolongée des fonctions circulatoire et respiratoire spontanées, la cessation irréversible des fonctions cérébrales peut être constatée par tout moyen reconnu par les normes de la pratique médicale courante. »). Pour des observations concernant l'application de ce critère par rapport au *Code criminel*, voir *id.*, p. 26. Voir également *Kitching*, précité, note 565.

567. Pour des observations concernant les dispositions du *Code criminel* applicables aux donneurs (vivants) et aux receveurs d'organes, voir *supra*, le texte accompagnant la note 516.

vivants ne satisfont pas aux critères de détermination de la mort[568], un problème de politique pénale se pose. Faut-il modifier la définition de la mort, pour tenir compte du cas de ces enfants presque entièrement privés, à leur naissance, de la partie supérieure de l'encéphale, qui meurent généralement dans les soixante-douze heures ? Ou faut-il les exclure de l'application de cette définition et permettre aux médecins de transplanter leurs organes dans le corps de malades qui auront ainsi une chance d'être sauvés ? Si le problème se pose, c'est en raison, d'une part, du fait que la médecine a besoin d'organes prélevés sur des nouveau-nés et, d'autre part, de l'impuissance de la science médicale face au nouveau-né anencéphale.

L'anencéphalie — le terme signifie littéralement « ne possédant pas d'encéphale[569] » — désigne une malformation congénitale caractérisée par l'absence d'encéphale, de voûte crânienne et du cuir chevelu[570]. Cette anomalie, dont les causes demeurent inconnues[571], toucherait un nouveau-né sur 3 226 ; entre quarante et soixante pour cent des anencéphales naissent vivants[572]. Ces derniers ne survivent normalement que quelques heures ou quelques jours ; un tout petit nombre survivent quelques semaines, voire quelques mois[573]. Il semble qu'environ cinquante nouveau-nés meurent chaque années au Canada des suites de l'anencéphalie et d'autres anomalies semblables[574] ; les États-Unis enregistrent entre trois cents et six cents décès par an[575]. Un meilleur dépistage prénatal pourrait diminuer le nombre de nouveau-nés anencéphales[576]. On estime aux États-Unis que la médecine aurait besoin tous les ans de quelque cinq cents foies et mille deux cents cœurs de nouveau-nés[577] ; pour le Canada, cela pourrait signifier une demande de cinquante à soixante foies et de quelque cent vingt cœurs[578].

L'impuissance de la médecine devant l'anencéphalie, le désir des parents de donner un sens à la tragédie qui les frappe et le besoin d'organes ont entraîné certaines propositions et certaines mesures visant à faciliter le prélèvement d'organes sur des anencéphales vivants. Certaines de ces initiatives semblent avoir été une réussite du point de vue médical :

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568. Des certificats de décès sont généralement établis pour ces enfants, ce qui semble indiquer qu'on les tient pour nés « vivants ».

569. *Nouveau Larousse médical*, édition revue et corrigée, Paris, Librairie Larousse, 1986, p. 62.

570. THE MEDICAL TASK FORCE ON ANENCEPHALY, « The Infant with Anencephaly » (1990), 322:10 *N. Engl. J. Med.* 669 [ci-après désigné MTFA].

571. Voir Jack A. PRITCHARD, Paul C. MACDONALD et Norman F. GANT, *Williams Obstetrics*, 17e éd., Norwalk (Conn.), Appleton-Century Crofts, 1985, p. 802.

572. Jeffrey R. BOTKIN, « Anencephalic Infants as Organ Donors » (1988), 82:2 *Pediatrics* 250, 251.

573. Voir STATISTIQUE CANADA, *Mortalité, liste sommaire des causes, la statistique de l'état civil, volume III*, Ottawa, Statistique Canada, 1984-1988, n° 84-206 pour les années 1981-1986 (on y signale que quelques nouveau-nés anencéphales ont survécu de un à dix mois après la naissance).

574. *Ibid.* Le nombre de décès imputables à l'« anencéphalie ou autres conditions semblables » (répertoire international n° 740) signalés pour les années 1981 à 1986 est le suivant : 1986-52 ; 1985-66 ; 1984-52 ; 1983-78 ; 1982-76 ; 1981-87.

575. J.R. BOTKIN, *loc. cit.*, note 572, 251. Voir également D. Alan SHEWMON et autres, « The Use of Anencephalic Infants as Organ Sources — A Critique » (1989), 261:12 *JAMA* 1773, 1774.

576. J.R. BOTKIN, *loc. cit.*, note 572, 255.

577. *Ibid.*

578. À supposer que les besoins canadiens équivalent à 10 % des besoins américains.

[TRADUCTION]

Bébé Gabrielle, née au Canada et ensuite transférée au Centre médical universitaire Loma Linda, en Californie, était anencéphale. Lorsque les parents ont appris l'état de leur fille et les conséquences dévastatrices de l'anencéphalie, [...] ils ont dû se résoudre au fait inexorable que, dès sa naissance, elle serait engagée dans le processus d'une mort imminente [...]

Dans l'espoir que leur fille « touche d'autres personnes et contribue à la vie d'une façon quelconque », les parents de bébé Gabrielle ont pris les mesures nécessaires afin que ses organes soient donnés à des bébés à qui il fallait de toute urgence transplanter des organes sains. Un de ces enfants était bébé Paul Holc, atteint du syndrome de l'hypoplasie du cœur gauche. Bébé Paul a reçu le cœur de Gabrielle ; un mois après la transplantation, il est sorti de Loma Linda, et il profite d'une deuxième chance de mener une vie saine et productive[579].

D'autres initiatives médicales n'ont pas donné d'aussi bons résultats[580].

En pratique, quatre solutions au moins sont envisageables en ce qui a trait au prélèvement de tissus et d'organes sur des nouveau-nés anencéphales. Chacune soulève des difficultés ressortissant au droit pénal et à l'éthique :

(1) Donner les soins normaux : Donner au nouveau-né, jusqu'à son dernier souffle, les soins normaux et veiller à ce qu'il souffre le moins possible, ce qui diminue la possibilité de prélever des organes viables, mais n'empêche pas le don de tissus[581].

(2) Présumer la mort cérébrale : Considérer que le nouveau-né anencéphale est en état de mort cérébrale[582], qu'il était mort au moment de sa naissance[583], qu'il est privé d'encéphale[584] ou qu'il est mort-né[585], pour l'exclure de l'application du critère traditionnel de la détermination de la mort (cessation des fonctions cardiaques et respiratoires), ou du critère plus récent consistant dans la notion de mort cérébrale,

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579. Andrea K. SCOTT, « Death Unto Life: Anencephalic Infants as Organ Donors? » (1988), 74 *Va. L. Rev.* 1527, 1528. Voir également T.C. FREWEN et autres, « Anencephalic Infants and Organ Donation: The Children's Hospital of Western Ontario Experience » (1990), 22:3 *Transplant. Proc.* 1033 ; George J. ANNAS, « From Canada with Love: Anencephalic Newborns as Organ Donors » (1987), 17:6 *Hast. Cent. Rep.* 36.

580. Voir Joyce L. PEABODY, Janet R. EMERY et Stephen ASHWAL, « Experience with Anencephalic Infants as Prospective Organ Donors » (1989), 321:6 *N. Engl. J. Med.* 344 (l'Université Loma Linda conclut qu'il n'est habituellement pas possible, vu les restrictions du droit actuel, de prélever des organes solides en vue de transplantations). Voir également « Anencephalic Organ Donor Program Suspended: Loma Linda Report Expected to Detail Findings » (1988), 260:12 *JAMA* 1671.

581. D.A. SHEWMON et autres, *loc. cit.*, note 575, 1778.

582. Voir CONFERENCE OF MEDICAL COLLEGES (Grande-Bretagne), « The Working Party on Organ Transplantation in Neonates » (1988), 14:3 *J. Med. Ethics* 164 ([TRADUCTION] « Chez l'adulte, la mort cérébrale et l'apnée sont considérés comme des signes de la mort. Le groupe de travail est d'avis, par analogie, que chez ces nouveau-nés, l'absence d'encéphale et l'apnée seraient également considérés comme des signes de la mort.).

583. A.K. SCOTT, *loc. cit.*, note 579, 1565. Voir également Jay A. FRIEDMAN, « Taking the Camel by the Nose: The Anencephalic as a Source for Pediatric Organ Transplants » (1990), 90 *Colum. L. Rev.* 917.

584. Michael R. HARRISON, « The Anencephalic Newborn as Organ Donor » (1986), 16:2 *Hast. Cent. Rep.* 21.

585. Voir Bernard M. DICKENS, « The Infant as Donor: Legal Issues » (1988), 20:4 (Suppl. 5) *Transplant. Proc.* 50, 52.

et ainsi permettre aux médecins de pratiquer une gamme plus étendue d'interventions médicales susceptibles d'augmenter le nombre d'organes viables prélevés à des fins de transplantation.

(3) Élaborer des protocoles médicaux : Se conformer au critère de la mort cérébrale et élaborer des protocoles de refroidissement médical[586] ou de respiration assistée[587], en vue de maximiser les chances de succès des prélèvements d'organes.

(4) Instituer une catégorie spéciale : Considérer les enfants anencéphales vivants comme une « catégorie spéciale » d'êtres, à savoir des non-personnes qui méritent un traitement spécial.

La première et la troisième solution concernent d'une manière générale les pratiques médicales. Les difficultés d'ordre juridique qu'elles soulèvent ne sont pas négligeables, mais beaucoup d'entre elles peuvent être examinées dans le cadre des propositions portant sur la mort cérébrale et l'établissement d'une catégorie spéciale.

(1) Nouvelle définition de la mort cérébrale

Ceux qui proposent que les anencéphales nés vivants soient considérés comme en état de mort cérébrale, privés d'encéphale ou morts-nés, ou qui souhaitent les exclure de l'application du critère de la mort cérébrale, se trouvent jusqu'à un certain point à remettre en question ce critère. On est alors forcément amené à modifier ou à réaffirmer l'objet et le rôle de celui-ci, de même que les principes qui le sous-tendent.

Vingt ans se sont écoulés depuis qu'un comité a proposé, pour la première fois en Amérique du Nord, qu'on abandonne la définition traditionnelle de la mort — cessation des fonctions cardiaque et respiratoire —, pour recourir plutôt au critère de la cessation irréversible de toutes les fonctions cérébrales[588]. Cette nouvelle définition, à l'instar de l'ancienne, était fondée sur la technologie et les besoins médicaux de l'époque. Les appareils assurant mécaniquement la respiration et la circulation en étaient venus à être d'utilisation courante en médecine, au même titre que le stéthoscope. Mais une question se posait dès lors : si un patient pouvait être maintenu « en vie » à l'aide d'un respirateur mécanique pendant une période indéfinie, sans manifester quelque réaction ni quelque activité cérébrale, quelle était donc sa situation sur le plan juridique ? Suivant les définitions traditionnelles de la vie et de la mort, le droit comme la médecine tendaient à considérer qu'il était en vie, malgré l'absence de respiration et de circulation spontanées.

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586. A. Kantrowitz et autres, « Transplantation of the Heart in an Infant and an Adult » (1968), 22:6 *Am. J. Cardiology* 782.

587. Voir J.L. Peabody et autres, *loc. cit.*, note 580.

588. Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, « A Definition of Irreversible Coma » (1968), 205:6 *JAMA* 337.

En 1970, le Kansas devenait le premier État nord-américain à définir dans un texte législatif la mort cérébrale[589]. Le Manitoba fera de même en 1975[590]. Lorsque, cinq ans plus tard, la Commission de réforme du droit a décidé de se pencher sur la question, un large consensus s'était dégagé en Amérique du Nord sur les plans médical, juridique et éthique, par lequel on reconnaissait que la cessation irréversible de la totalité des fonctions cérébrales d'une personne équivalait à la mort de cette dernière. Le nouveau critère a été conçu comme un complément au critère traditionnel. Le critère de la mort cérébrale a été adopté dans la jurisprudence pénale canadienne[591], dans la loi uniforme sur les tissus

589. Kan. Stat. Ann. s. 77-202 (1970).

590. *Loi sur les statistiques de l'état civil*, L.R.M. 1987, ch. V-60.

591. Voir *Kitching*, précité, note 565. Voir cependant *R. c. Green* (1988), 43 C.C.C. (3e) 413 (C.S. C.-B.). L'affaire *Green* présentait des circonstances plutôt exceptionnelles ; l'accusé prétendait qu'il ne pouvait être accusé du meurtre d'une personne déjà décédée. Voir D. STUART, *op. cit.*, note 506, p. 109. L'accusé Green avait logé deux balles dans la tête de la victime, peu de temps après qu'un autre défendeur eut lui-même tiré un coup de feu et atteint la victime à la tête. Apparemment, chacune des balles aurait suffi à causer la mort. En faisant valoir que la victime était déjà morte, Green forçait le tribunal à déterminer, en droit, à quel moment le décès était survenu et ce qui l'avait causé, pour statuer sur la responsabilité de l'accusé à l'égard de l'homicide. Lorsque le moment du décès fait l'objet d'une controverse juridique, les tribunaux essaient, avec raison, de résoudre la question en se fondant sur le témoignage d'un médecin expert. Voir *Defining Death*, *infra*, note 594, p. 78.

Dans l'affaire *Green*, le tribunal a refusé de recourir au critère de la mort cérébrale pour tenter de répondre à la question. Il a retenu le critère traditionnel de la mort — la cessation des fonctions cardiaque et respiratoire — pour deux raisons semble-t-il. Premièrement, certains indices permettaient de penser que, si la victime avait cessé de respirer après le premier coup de feu, son cœur battait peut-être encore lorsqu'elle a été atteinte par les deux coups de feu du défendeur Green. Deuxièmement, en raison apparemment du traumatisme cérébral subi par la victime, le tribunal semblait craindre que la Couronne ne réussisse pas à prouver que la victime était toujours vivante (« cérébralement vivante »), si l'on appliquait le critère de la mort cérébrale. Le tribunal a jugé que le critère de la mort cérébrale était [TRADUCTION] « une norme tout à fait irréaliste dans le contexte du droit pénal ».

La preuve médicale présentée dans cette affaire est limitée. Toutefois, nous voulons souligner trois choses en ce qui concerne la « mort cérébrale ». Premièrement, la proposition de la CRD porte sur la cessation irréversible de toutes les fonctions cérébrales (*brain death*) et non des seules fonctions néo-corticales (*cerebral death*). Deuxièmement, en vertu du critère préconisé par la CRD, la mort cérébrale « peut être constatée à partir de l'absence prolongée de fonctions circulatoire et respiratoire spontanées ». Voir Rapport n° 15, *op. cit.*, note 1. Par conséquent, selon les circonstances médicales précises, le fait que le cœur batte peut indiquer qu'il n'y a pas mort cérébrale. Voir *Defining Death*, *infra*, note 594, p. 15.

Troisièmement, les tribunaux canadiens, britanniques et américains ont, dans les faits, conclu que le critère de la mort cérébrale pouvait aider à déterminer le moment et la cause du décès dans des cas d'homicide plus caractéristiques : à savoir, quand la victime d'un homicide est amenée à la salle d'urgence d'un hôpital et est maintenue en vie par des mécanismes de soutien artificiel dont on cesse l'utilisation une fois la mort constatée, et que le défendeur prétend que c'est la cessation du soutien mécanique qui est la cause du décès ou qui en détermine le moment. *Kitching*, précité, note 565 ; *R. c. Malcherek* ; *R. c. Steel*, [1981] 2 All E.R. 422. *Eulo*, précité, note 565. Voir en général David B. SWEET, « Homicide by Causing Victim's Brain-Dead Condition », 42 A.L.R. 4th 742. Le rejet systématique par les tribunaux des arguments présentés par les accusés dans ces causes, et l'adoption du critère de la norme de la mort cérébrale en vue de préciser la cause ou le moment du décès, sembleraient indiquer que ce critère s'avère utile pour l'établissement de la responsabilité en matière d'homicide. Ces problèmes seront sans doute examinés de manière plus approfondie dans la jurisprudence et la doctrine.

humains[592] et par les membres de la profession médicale[593]. Quelque quarante-neuf États américains[594] et la plupart des pays de l'Europe de l'Ouest[595] ont fait de même.

L'un des principaux objectifs auxquels répondait l'établissement du critère de la mort cérébrale consistait à préciser les droits et les devoirs de chacun au regard du droit, en utilisant une norme mieux adaptée à notre époque. Une définition claire de la mort diminue l'incertitude et la confusion en ce qui concerne le moment où une personne peut être considérée comme morte du point de vue du droit. Les familles disposent ainsi d'une norme sociale moderne qui les aide à prendre certaines décisions difficiles lorsque l'interruption du traitement d'une personne peut être envisagée. Par ailleurs, on se trouve aussi à clarifier les obligations professionnelles, les droits des patients et les limites de la responsabilité pénale, ce qui facilite le prélèvement et la transplantation d'organes.

La Commission de réforme du droit du Canada était convaincue que l'adoption d'un nouveau critère juridique de la mort devait se faire dans le respect de certains principes ressortissant à la politique pénale et à l'ordre public. Premièrement, la réforme devait viser à éliminer la confusion ; elle devait donc répondre à un souci ce clarté et orienter les décision prises par les professionnels et les citoyens en général[596]. Deuxièmement, elle devait favoriser l'uniformité et s'appliquer de la même façon dans tous les cas où la détermination de la mort pose un problème[597]. Ce principe découle de la fiabilité et de l'uniformité du critère traditionnel de la cessation des fonctions cardiaque et respiratoire, et vise à empêcher la prolifération des concepts et des définitions de la mort, qui serait une source de confusion. La commission présidentielle américaine a exprimé l'avis que le nouveau critère [TRADUCTION] « ne devait pas renforcer la fausse impression qu'il existe plusieurs " sortes de mort ", définies en fonction de fins différentes, et que certaines personnes sont donc " plus mortes " que d'autres[598]. »

Troisièmement, la réforme devait « correspondre aux standards et aux critères généralement acceptés par l'ensemble du public canadien[599] ». L'élaboration d'un

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592. Voir *infra*, note 835.

593. CONGRÈS CANADIEN DES SCIENCES NEUROLOGIQUES, *loc. cit.*, note 194 ; CANADIAN CONGRESS COMMITTEE ON BRAIN DEATH, *loc. cit.*, note 194.

594. Voir NEW JERSEY COMMISSION ON LEGAL AND ETHICAL PROBLEMS IN THE DELIVERY OF HEALTH CARE, *Problems and Approaches in Health Care Decision-Making: The New Jersey Experience*, New Jersey, la Commission, 1990, p. 11. THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, *The Determination of Death*, 2e éd., New York, The Task Force, 1989, p. 4 [ci-après NYTF]. Voir en général PRESIDENT'S COMMISSION, *Defining Death: A Report on the Medical, Legal and Ethical Issues in the Determination of Death*, Washington (D.C.), la Commission, 1981 [ci-après *Defining Death*].

595. Voir *infra*, ch. IV, section II.C.

596. CRD, *Les critères de détermination de la mort*, Document de travail n° 23, Ottawa, Approvisionnements et Services Canada, 1979, p. 55.

597. *Id.*, pp. 57-58.

598. *Defining Death*, *op. cit.*, note 594, p. 60.

599. Document de travail n° 23, *op. cit.*, note 596, p. 60.

consensus dans la société nord-américaine au cours de la décennie précédant la proposition de la Commission a permis au public de tirer profit des délibérations de la communauté médicale, juridique et bioéthique sur le critère de la mort cérébrale. Le principe de l'acceptabilité est du reste un des facteurs ayant amené la Commission à conclure qu'il serait malavisé d'adopter comme critère la mort du cortex :

> Sur le plan social, il nous paraît illusoire de penser que le public serait prêt à considérer comme décédée une personne dont le cortex est totalement détruit, mais qui continue toutefois à avoir une fonction cardiaque et respiratoire spontanée et autonome. Tel est apparemment le cas de Karen Quinlan aux U.S.A.[600]

Karen Ann Quinlan, qui gisait dans un état végétatif permanent sans chance de guérison lorsque ses parents ont demandé au tribunal de permettre le débranchement du respirateur, n'avait plus de fonctions cérébrales au sens étroit du terme mais conservait une certaine activité du tronc cérébral[601]. Les patients en état de mort cérébrale ne peuvent respirer spontanément et ils ne répondent pas à la lumière, à la douleur ou aux stimuli sonores ; en revanche, ceux qui ont certaines activités du tronc cérébral peuvent respirer spontanément[602]. C'est ainsi qu'après le débranchement des appareils, Karen Quinlan a survécu pendant des années. Il n'existe toujours pas de consensus au sein de la société canadienne, ni même en Amérique du Nord, sur la question de savoir si la mort du cortex équivaut ou non à la mort du patient[603]. L'adoption d'un tel critère signifierait que les anencéphales, et un nombre de patients estimé entre mille et dix mille qui, comme Karen Quinlan, sont dans un état végétatif permanent au Canada, pourraient devenir des sources d'organes, malgré l'existence de fonctions cardiaque et respiratoire spontanées[604].

Enfin, la Commission était — et est toujours — d'avis que les critères de détermination de la mort ne doivent pas être déterminés « uniquement ou principalement à partir des pratiques conçues pour les greffes d'organes[605] ». Elle préconise donc l'application d'un principe de neutralité : la réforme ne doit ni freiner ni favoriser la transplantation d'organes. On reconnaît ainsi que la société a d'autres intérêts légitimes en ce qui a trait à la détermination de la mort, intérêts qui doivent eux aussi être pris en compte.

Ces principes ont une incidence directe sur la question de savoir s'il y a lieu, comme le proposent certains, d'exclure les anencéphales de l'application du critère de la mort

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600. Rapport n° 15, *op. cit.*, note 1, p. 18.

601. *Re Quinlan*, 355 A. 2d 647 (N.J. 1976), cert. refusé, 429 U.S. 922. Dans la foulée de l'affaire *Quinlan*, une décision récente est déterminante : *Cruzan* c. *Missouri*, 110 S. Ct 2841 (1990).

602. Voir B. Young, W. Blume et A. Lynch, « Brain Death and the Persistent Vegetative State: Similarities and Contracts » (1989), 16:4 *Can. J. Neurol. Sci.* 388 ; American Medical Association, Council on Scientific Affairs and Council on Ethical and Judicial Affairs, « Persistent Vegetative State and the Decision to Withdraw or Withhold Life Support » (1990), 263:3 *JAMA* 426 ; American Academy of Neurology, « Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient » (1989), 39:1 *Neurology* 125.

603. Voir NYTF, *op. cit.*, note 594, p. 10.

604. Voir P. Taylor, *loc. cit.*, note 250. Voir également David Randolph Smith, « Legal Recognition of Neocortical Death » (1986), 71 *Cornell L. Rev.* 850.

605. Voir Rapport n° 15, *op. cit.*, note 1, p. 13 ; Document de travail n° 23, *op. cit.*, note 596, p. 61.

cérébrale ou de modifier ce critère. De telles propositions portent atteinte au principe de la neutralité, parce qu'elles répondent directement au souci de favoriser le prélèvement des organes d'une catégorie de nouveau-nés gravement handicapés. On ne saurait justifier de telles modifications aux critères de détermination de la mort seulement par l'intérêt qu'elles présentent à l'égard de la transplantation d'organes, parce qu'au-delà de sa signification médicale, la mort est un concept théologique, moral et juridique[606]. Une nouvelle définition qui serait exclusivement fondée sur les besoins de la médecine en matière de transplantations pourrait, en outre, donner une impression d'arbitraire et de traitement inéquitable, parce que le droit risquerait alors de paraître troquer les intérêts des receveurs potentiels contre ceux d'enfants gravement handicapés et de leur famille[607]. Depuis des années, les textes médicaux faisant autorité qualifient de monstres les enfants anencéphales[608]. Comme on attache de plus en plus d'importance aux droits et à la protection des personnes atteintes de déficience légère ou grave, la modification des critères juridiques de la détermination de la mort pour une catégorie particulière de patients [TRADUCTION] « soulève des questions troublantes concernant l'évaluation de la qualité de la vie dans le processus de la détermination de la mort[609]. » À l'extrême, le fait d'envisager une telle modification nous force à nous demander si, en droit, certaines morts et certains cerveaux sont [TRADUCTION] « plus égaux que d'autres[610] », et si les anencéphales ne risquent pas alors d'être les victimes d'une discrimination injustifiée en raison de leur handicap physique[611]. On voit ainsi combien il importe que toute réforme se fasse dans le respect des droits fondamentaux de la personne.

Deuxièmement, l'adoption de ces propositions ne contribuerait vraisemblablement pas à dissiper l'incertitude qui persiste au sujet de l'application concrète du critère de la mort cérébrale actuellement en vigueur. On constate encore chez un nombre inquiétant de professionnels de la santé travaillant dans le domaine une certaine confusion quant au

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606. NYTF, *op. cit.*, note 594, p. 6. Voir cependant Edward W. KEYSERLINGK, « A Legal Definition of Death: Can It Affect Supply of Tissue and Organs? » (1985), 17:6 (Suppl. 4) *Transplant. Proc.* 47, 48-49. ([TRADUCTION] « Il demeure que les transplantations d'organes constituent l'une des raisons d'être et des justifications les plus importantes de ces lois, sinon la plus importante. Rien ne justifie non plus la crainte souvent exprimée ou implicite que cela serait contraire à l'éthique. Après tout, comme on l'a fait remarquer, la préservation de la vie et de la santé sont les valeurs auxquelles notre société attache le plus grand prix, et la transplantation d'organes est l'un des moyens d'atteindre ces objectifs dans certains cas. »).

607. Voir « L'Association médicale mondiale adopte des déclarations sur des questions d'ordre bioéthique et autre » (1988), 39:1 *R.I.L.S.* 286, extraits cités à l'annexe A, *infra*, pp. 228-229. (« Un projet de transplantation d'organe ne justifie aucunement le relâchement des exigences en matière d'éthique médicale. Les mêmes exigences doivent être respectées, que le patient soit un donneur potentiel ou non. »).

608. Comparer J.A. PRITCHARD, P.C. MACDONALD et N.F. GRANT, *op. cit.*, note 571, p. 802 (« monster ») et F. Gary CUNNINGHAM, Paul C. MACDONALD et Norman F. GANT (dir.), *Williams Obstetrics*, 18e éd., Norwalk (Conn.), Appleton & Lange, 1989, p. 575 (« child »). Voir en général James W. WALTERS, « Are Anencephalic Infants Monstrosities? » (1989), 2:28 *BioLaw* S:211.

609. NYTF, *op. cit.*, note 594, p. 10.

610. B. FREEDMAN, « The Anencephalic Organ Donor: Affect, Analysis, and Ethics » (1988), 20:4 (Suppl. 5) *Transplant. Proc.* 57, 61.

611. Voir *infra*, section IV

diagnostic et à la détermination de la mort cérébrale[612]. En modifiant la définition de la mort pour la rendre applicable à un certain groupe de patients, on risquerait donc de nuire à l'uniformité, de donner le signal d'une prolifération des critères de la mort et de favoriser la confusion au sujet des critères qui s'appliquent et devraient s'appliquer à tel ou tel groupe de patients :

> [TRADUCTION]
> Comme la société envisage d'élargir le bassin de donneurs potentiels en y ajoutant d'autres patients souffrant de lésions cérébrales, qui sont clairement vivants au regard des critères juridiques et médicaux en vigueur actuellement, la confusion risque de s'accroître. Ceux qui ont accepté le critère de la mort cérébrale parce qu'ils ont une conception plus large du cerveau ou simplement parce qu'ils croient que les patients en état de mort cérébrale sont inéluctablement engagés dans le processus de la mort pourraient trouver acceptable qu'on prélève les organes de certains patients actuellement considérés comme vivants, par exemple, les anencéphales ou les personnes dans un état végétatif permanent, parce que ces patients présentent des caractéristiques cliniques compatibles avec une conception moins étroite de la mort. Certains pourraient essayer de faire modifier les critères juridiques de la mort, afin de supprimer tout obstacle s'opposant à l'utilisation comme donneurs d'autres types de patients souffrant de lésions cérébrales graves. Si l'on ne parvient pas à établir un consensus plus large sur le concept de la mort, ces « combines conceptuelles » seront simplement une autre source de confusion, voire de résistance, à l'égard du prélèvement d'organes[613].

Troisièmement, une modification du critère ne répondrait pas au principe de l'acceptabilité. Le fait que, dans la littérature spécialisée consacrée au cas des anencéphales, on utilise les notions d'absence d'encéphale, de mort cérébrale et d'enfants mort-nés incite à croire que la médecine, la bioéthique et le droit en sont encore aux premières étapes dans la recherche d'un consensus sur la situation des anencéphales aux points de vue juridique et moral. La diversité d'opinions, d'intérêts et de solutions est certes très saine, et nécessaire à un véritable débat, mais elle s'avère peu utile lorsqu'il s'agit d'élaborer un nouveau critère juridique. L'absence de consensus à cette étape signifie également que l'adoption de l'une ou l'autre des solutions actuellement proposées ne correspondrait pas « aux standards et aux critères généralement acceptés par l'ensemble du public canadien[614]. » Car aussi bien suivant le critère traditionnel (cessation des fonctions cardiaque et respiratoire) que suivant le critère moderne (mort cérébrale), l'enfant qui naît anencéphale et se trouve ainsi gravement handicapé du point de vue neurologique, naît vivant :

> [TRADUCTION]
> Manipuler la définition de la mort — pour viser les enfants anencéphales qui, de façon spontanée, respirent, tètent, pleurent, etc., ce qui les distingue des êtres morts que la société est généralement disposée à qualifier de cadavres et à inhumer — pourrait saper la confiance

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612. Stuart J. YOUNGER et autres, « "Brain Death" and Organ Retrieval: A Cross-sectional Survey of Knowledge and Concepts Among Health Professionals » (1989), 261:15 *JAMA* 2205 (des 195 professionnels de la santé interrogés, 35 % ont décrit correctement la mort cérébrale, 58 % n'ont pu utiliser un concept cohérent et constant de la mort, 19 % avaient de la mort une définition suivant laquelle le critère de la mort cérébrale serait modifié de telle sorte que les anencéphales et les patients en état végétatif permanent seraient considérés comme morts). Voir également ONT, *op. cit.*, note 29, p. 235.

613. S.J. YOUNGER et autres, *loc. cit.*, note 612, 2210.

614. Voir Rapport n° 15, *op. cit.*, note 1, p. 13 ; Document de travail n° 23, *op. cit.*, note 596, p. 60.

déjà faible du public à l'égard de la détermination de la mort fondée sur le critère de la mort cérébrale. Il en résulterait selon toute vraisemblance une diminution du nombre de dons d'organes provenant de toutes les catégories de donneurs potentiels, comme cela s'est produit en Angleterre à la suite d'une émission télévisée où l'on avait mis en doute la justesse des diagnostics de mort cérébrale[615].

Certains seront tentés de considérer qu'il s'agit là de propos exagérés. Pourtant, il est permis de croire que si les gens hésitent à s'engager dans le processus du don d'organes, c'est notamment parce qu'ils craignent un diagnostic prématuré de mort[616]. L'établissement d'un critère de détermination de la mort est susceptible de favoriser les transplantations d'organes, mais l'existence d'un parti pris injustifié en la matière pourrait miner la confiance du public à l'égard du droit comme à l'égard du processus de don d'organes[617]. Il est donc légitime de chercher à établir un lien entre la pratique médicale, la définition juridique de la mort et la confiance du public ainsi que sa volonté de participer au processus de don d'organes. La fragilité même de ce lien incite à la prudence et à la circonspection[618].

(2) Nouvelle définition de la personne

La possibilité d'un bienfait immédiat et concret pour le receveur éventuel et les parents du donneur, ainsi que l'apparente « absence de préjudice » pour les bébés anencéphales, poussent certaines personnes à préconiser l'application à l'égard de ces derniers de règles particulières :

> [TRADUCTION]
> [L]es bébés nés sans encéphale sont tellement différents des autres bébés vivants — et leur avenir est si radicalement limité — qu'il est permis, si les parents y consentent librement et en toute connaissance de cause, de prélever leurs organes en vue de transplantations. « [. . .] l'anencéphalie est une anomalie tellement spéciale, tellement différente de toutes les autres [. . .] que les bébés atteints de cette terrible malformation devraient être considérés comme formant une catégorie tout à fait à part, à l'égard de laquelle devraient s'appliquer des règles spéciales[619]. »

Le prélèvement d'organes serait dès lors possible sur des anencéphales même si les critères de la mort cérébrale ne sont pas remplis.

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615. D.A. SHEWMON et autres, *loc. cit.*, note 575, 1778.

616. Voir B.E. NOLAN et N.P. SPANOS, *loc. cit.*, note 225. Voir également USTF, *op. cit.*, note 29, et J. AREEN, *loc. cit.*, note 226, 562.

617. Indépendamment du fait que la détermination de la mort influe — parfois de manière choquante — sur d'autres intérêts juridiques légitimes, notamment les droits successoraux, les poursuites pénales, les actions civiles et le débranchement des appareils de soutien artificiel à d'autres fins que la transplantation. Voir E.W. KEYSERLINGK, *loc. cit.*, note 606, 47-48.

618. Accord, *Defining Death*, *op. cit.*, note 594, pp. 58-59.

619. ETHICS AND SOCIAL IMPACT COMMITTEE TRANSPLANT POLICY CENTER, « Anencephalic Infants as Sources of Transplantable Organs » (1988), 18:5 *Hast. Cent. Rep.* 28 [ci-après désigné ESIC].

Du point de vue du droit pénal, cette solution soulève plusieurs difficultés d'ordre général. D'une part, l'idée qu'il est parfois acceptable d'interrompre des soins « thérapeutiquement inutiles[620] » et d'administrer des soins palliatifs ayant pour conséquence d'abréger la vie[621] du mourant — idée défendue par la Commission — pourrait orienter les décisions relatives au traitement. Mais d'autre part, les réformes proposées par la Commission au chapitre du droit pénal n'ont pas encore été mises en œuvre. Par conséquent, tout traitement médical provoquant[622] ou hâtant la mort[623] d'un être humain, ainsi que tout diagnostic prématuré de mort[624] concernant un être humain risquent d'être contraires aux dispositions actuelles du *Code criminel*[625].

Des auteurs ont avancé que, vu l'impuissance de la médecine face aux bébés anencéphales et vu l'objectif poursuivi (sauver des vies), le moyen de défense de la « nécessité » pourrait sans doute être invoqué dans ce contexte[626]. D'autres ne sont pas convaincus par l'argument[627]. La nature des difficultés touchant la responsabilité pénale et, d'une manière générale, la difficulté d'appliquer le critère de la mort cérébrale aux anencéphales et à d'autres nouveau-nés[628], semblent conduire à la conclusion qu'il ne serait pas très utile d'élaborer et d'appliquer dans le domaine de la médecine la solution fondée sur l'établissement d'une catégorie spéciale d'être humains.

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620. CRD, *Euthanasie, aide au suicide et interruption de traitement*, Rapport n° 20, Ottawa, Approvisionnements et Services Canada, 1983, p. 29.

621. Rapport n° 31, *op. cit.*, note 116, p. 69.

622. Voir *Kitching*, précité, note 565. Voir également l'art. 269 du *Code criminel* (infliction illégale de lésions corporelles).

623. *Code criminel*, art. 226 : Hâter la mort :

> Lorsqu'une personne cause à un être humain une blessure corporelle qui entraîne la mort, elle cause la mort de cet être humain, même si cette blessure n'a pour effet que de hâter sa mort par suite d'une maladie ou d'un désordre provenant de quelque autre cause.

624. Voir *Eulo*, précité, note 565 et *Kitching*, précité, note 565.

625. Certains de ces problèmes pourraient également se poser dans le cas de la solution consistant dans l'établissement de protocoles médicaux.

626. Voir M.J. TUTTLE, « Transplanting Organs from Anencephalic Infants » (lettre) (1987), 136:8 *Journal de l'Association médicale canadienne* 797. Voir également Diana BRAHAMS, « Fetal Spare Parts » (1988), 1:8582 *Lancet* 424. On trouvera une discussion sur les moyens de défense reposant sur la nécessité et l'ordre public dans le Document de travail n° 26, *op. cit.*, note 370, pp. 47, 70.

627. Voir B.M. DICKENS, *loc. cit.*, note 585, 51 ([TRADUCTION] « Il est douteux que l'homicide commis lorsqu'on hâte la mort d'un anencéphale pourrait être justifié ou excusé par la nécessité de sauver la vie du receveur. Le préjudice causé doit, objectivement, être peu important en comparaison des avantages espérés, mais même l'objectif de sauver la vie d'un enfant peut être insuffisant pour excuser le fait de mettre fin à celle d'un autre enfant, même d'un anencéphale qui mourra vraisemblablement peu de temps après. »).

628. Voir MFTA, *loc. cit.*, note 570, 672 ; CONGRÈS CANADIEN DES SCIENCES NEUROLOGIQUES, *loc. cit.*, note 194, 200B ([TRADUCTION] « La mort cérébrale n'a pas été assez bien étudiée chez les nouveau-nés, les bébés et les jeunes enfants pour qu'on soit en mesure de déterminer si les critères cliniques établis ci-dessus sont applicables à ces groupes »). Voir également TASK FORCE FOR THE DETERMINATION OF BRAIN DEATH IN CHILDREN, « Guidelines for the Determination of Brain Death in Children » (1987), 37 *Neurology* 1077 ; David L. COULTER, « Neurologic Uncertainty in Newborn Intensive Care » (1987), 316:14 *N. Engl. J. Med.* 840.

Cette solution soulève également des problèmes d'ordre éthique[629] tenant au conflit qui surgit en l'occurrence entre les principe de bienfaisance et de non-malfaisance, ainsi qu'à des divergences de vues sur la relation entre le corps et la personne.

Par rapport au devoir éthique de faire du bien, l'établissement de règles spéciales à l'égard des anencéphales semble intéressant. Pour les receveurs potentiels, cela peut en effet signifier la vie, bien que le succès à long terme de la transplantation et la qualité de vie du bénéficiaire demeurent incertains[630]. Par ailleurs, le fait de pouvoir faire don des organes de leur enfant anencéphale mourant en vue de sauver des vies est susceptible d'apporter un réconfort aux parents et de donner un sens à la tragédie qui les frappe. Les avantages semblent donc de prime abord irrésistibles.

Mais ils ne sont peut-être pas déterminants, comme s'empressent de le signaler ceux qui défendent le point de vue opposé, en raison des préjudices susceptibles d'être causés. Cette possibilité de préjudices découle de l'incertitude médico-éthique, des inquiétudes relevant de la « pente glissante » et des torts moraux que pourrait entraîner le fait de considérer les nouveau-nés anencéphales comme des non-personnes. Premièrement, les affirmations suivant lesquelles[631] [TRADUCTION] « [l]es nouveau-nés anencéphales sont dépourvus de la capacité neurologique de ressentir la douleur[632] » et le diagnostic de l'anencéphalie est exact dans presque cent pour cent des cas[633] ne sont pas à l'abri de toute contestation. Les autorités les plus en vue s'entendent pour dire que le diagnostic de l'anencéphalie n'est pas infaillible, mais qu'il doit être établi selon des critères précis[634]. De plus, la conclusion que les nouveau-nés anencéphales sont incapables de ressentir de la douleur repose sur une comparaison faite avec des patients plus âgés qui sont dans un état végétatif permanent[635] — comparaison dont certains mettent en doute le bien-fondé[636]. Des auteurs prétendent en outre que parce que certains nouveau-nés anencéphales ont un tronc cérébral plus intact que d'autres, le degré de conscience ou d'inconscience peut varier[637]. Vu l'incertitude touchant ces prémisses médicales, le tort

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629. Comme nous l'avons déjà mentionné, nous nous penchons ici sur les aspects éthiques du prélèvement d'organes sur des nouveau-nés anencéphales afin de favoriser la densité de l'analyse.

630. Voir Abbyann LYNCH, « Use of the Anencephalic Infant as Organ Donor: Some " Public " Questions » (1988), 1:2 *Westminster Aff.* 1, 3. Comparer T.C. FREWEN et autres, *loc. cit.*, note 579.

631. D. Alan SHEWMON, « Anencephaly: Selected Medical Aspects » (1988), 18:5 *Hast. Cent. Rep.* 11, 14.

632. Arthur L. CAPLAN, « Ethical Issues in the Use of Anencephalic Infants as a Source of Organs and Tissues for Transplantation » (1988), 20:4 (Suppl. 5) *Transplant. Proc.* 42, 47. Voir également Robert C. CEFALO et H. Tristam ENGELHARDT, « The Use of Fetal and Anencephalic Tissue for Transplantation » (1989), 14:1 *J. Med. Phil.* 25, 32.

633. A.L. CAPLAN, *loc. cit.*, note 632, 48 ; ESIC, *loc. cit.*, note 619, 29.

634. Voir MFTA, *loc. cit.*, note 570, 670 ; D.A. SHEWMON, *loc. cit.*, note 631, 15.

635. D.A. SHEWMON, *loc. cit.*, 631, 14.

636. Voir MFTA, *loc. cit.*, note 570, 672 ; D.A. SHEWMON, *loc. cit.*, note 631, 14 ; B. YOUNG, W. BLUME et A. LYNCH, *loc. cit.*, note 602 et K.J.S. ANAND et P.R. HICKEY, « Pain and Its Effects in the Human Neonate and Fetus » (1987), 317:21 *N. Engl. J. Med.* 1321. L'anesthésie n'est généralement pas utilisée dans le cas des personnes tenues pour cérébralement morte. Thomas LEGGANS, « Anencephalic Infants as Organ Donors » (1989), 9 *J. Legal Med.* 449, 460-461.

637. Voir D.A. SHEWMON, *loc. cit.*, note 631, 15.

susceptible d'être causé aux anencéphales est peut-être plus important que semblent l'admettre certains partisans enthousiastes de la solution consistant à établir des règles particulières à l'égard de ces nouveau-nés. Dans la mesure où les prémisses médicales en question ne sont pas sans susciter certains problèmes, l'analyse éthique risque de s'en trouver viciée[638].

Deuxièmement, la solution de la « catégorie spéciale » soulève des craintes quant aux conséquences qu'elle pourrait éventuellement entraîner. Le fait de prélever les organes des nouveau-nés avant la mort de ces derniers ne risque-t-il pas d'ébranler la confiance du public dans le processus de prélèvement et de transplantation d'organes[639] ? Les femmes à qui l'on apprend que le fœtus qu'elles portent est anencéphale verront-elles leur autonomie compromise par les pressions les incitant à mener le fœtus à terme en vue de la transplantation d'organes ? N'en viendra-t-on pas ainsi à la négation du respect normalement accordé aux enfants qui ne présentent pas de malformations et à leurs parents[640] ? Si les nouveau-nés anencéphales sont considérées comme des « non-personnes », d'autres êtres ne risquent-ils pas également de subir le même sort, d'être rangés dans un bassin élargi de donneurs d'organes ? Pensons au cas des nouveau-nés atteints d'autres malformations neurologiques (spina-bifida, hydrocéphalie, par exemple), aux personnes atteintes d'une déficience mentale profonde[641] et aux patients hospitalisés se trouvant dans la même situation que Karen Anne Quinlan — à savoir, qui ne sont pas en état de mort cérébrale mais dans un état végétatif permanent[642].

Enfin, le simple fait d'établir des règles spéciales à l'égard des nouveau-nés anencéphales risque d'être contestable sur le plan moral, dans la mesure où l'on se trouve alors à battre en brèche un devoir éthique inspiré des principes kantiens[643]. La maxime « Agis de manière à traiter autrui jamais simplement comme un moyen, mais toujours en même temps comme une fin » s'applique aux receveurs potentiels, aux professionnels de la santé, aux parents des nouveau-nés anencéphales et à la société en général. Ceux qui préconisent le prélèvement des organes des anencéphales affirment que le devoir de respecter les personnes ne s'applique pas à ces êtres en raison de leur situation incertaine sur le plan moral[644]. Ils estiment en effet que le respect moral est dû aux « personnes », non seulement parce qu'elles font partie du genre humain, mais également parce qu'elles sont douées de sensations, de conscience ou de conscience de soi[645], et sont capables

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638. *Id.*, 14.

639. Voir, par exemple, A.L. CAPLAN, *loc. cit.*, note 632, 43-44. Voir également *supra*, notes 225-227.

640. Voir T. LEGGANS, *loc. cit.*, note 636, 455.

641. *Id.*, 460 et A. LYNCH, *loc. cit.*, note 630, 2.

642. Voir « New Arguments Voiced Over Use of Anencephalics as Organ Donors » (mai-juin 1989), *Hosp. Ethics* 6 [ci-après New Arguments]. Si l'on estime que les fondements moraux du prélèvement de tissus sont les suivants : [TRADUCTION] « veiller au respect de la liberté de choix, de la volonté et d'une rationalité réfléchie, tout en évitant de causer un préjudice grave au donneur », on pourra difficilement résister à ce que la règle soit étendue à ces autres catégories de « donneurs ». Voir A.L. CAPLAN, *loc. cit.*, note 632, 46.

643. New Arguments, *loc. cit.*, note 642, 7. Voir également *supra*, ch. II.

644. A.L. CAPLAN, *loc. cit.*, note 632, 47.

645. *Id.*, 48 ; T. LEGGANS, *loc. cit.*, note 636, 455 ; New Arguments, *loc. cit.*, note 642, 6-7. Voir également ESIC, *loc. cit.*, note 619, 29.

d'autonomie et de discernement[646]. Leur thèse s'appuie aussi sur un autre argument : comme les nouveau-nés anencéphales sont dépourvus des capacités mentales dont découlent les intérêts, ils sont aussi dépourvus, entièrement ou presque, des intérêts qui appellent habituellement le respect :

> [TRADUCTION]
> [I]l devient difficile de savoir comment interpréter le désir de respecter les intérêts de ces enfants. Ceux qui préconisent le respect de la dignité de tous les êtres humains doivent démontrer en quoi il y a atteinte à ce principe lorsqu'on ne l'applique pas aux enfants dépourvus de tout moyen susceptible de générer des intérêts[647].

Le devoir de respecter les personnes est alors réduit au devoir de ne pas causer de préjudice à autrui en portant atteinte à ses intérêts[648] — c'est-à-dire au devoir de non-malfaisance[649].

À côté du débat éthique sur le point de savoir si les morts peuvent subir des préjudices, il semble y avoir entre les partisans et les adversaires de la solution de la « catégorie spéciale » ou de la « non-personne » une divergence de vues fondamentale sur la relation entre le corps et la personne[650]. Les partisans tendent à réduire les « personnes » à leurs sensations ou à leurs facultés cognitives, en assimilant la notion de personne à celle d'être rationnel. Dès lors, le corps tend à perdre toute importance sur le plan moral. Par contre, ceux qui s'opposent au prélèvement d'organes sur les nouveau-nés anencéphales semblent avoir davantage tendance à considérer les personnes comme des êtres incarnés dans un corps ; le respect moral est alors dû tant au corps qu'aux attributs de la sensibilité et de la rationalité. Cette conception[651] échappe peut-être à toute justification rationnelle, parce que le respect ainsi accordé au corps tient vraisemblablement à des sentiments fondamentaux qui transcendent tout argument rationnel[652].

En somme, le fait de rejeter l'établissement d'une catégorie spéciale de « non-personnes » et de refuser de modifier les critères de la mort cérébrale a pour conséquence

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646. A.L. CAPLAN, *loc. cit.*, note 632, 48. Voir cependant B. FREEDMAN, *loc. cit.*, note 610, 57. ([TRADUCTION] « On tient que les être humains sont précieux ; et la qualité qui les distingue — l'un de l'autre, ou par rapport aux autres espèces — est l'activité mentale. Il ne s'ensuit pas toutefois que la valeur de l'homme tient exclusivement à l'activité mentale. Ce qui distingue une espèce ne caractérise pas nécessairement l'individu. Dans le cas des humains incapables d'activité mentale, d'autres fondements de la valeur passent au premier plan — des facteurs qui, dans le cas des personnes ayant des facultés normales, sont éclipsés par la lumière aveuglante de l'activité mentale. »).

647. A.L. CAPLAN, *loc. cit.*, note 632, 48.

648. Voir également R.C. CEFALO et H.T. ENGELHARDT, *loc. cit.*, note 632, 35-36.

649. Un rapprochement peut être établi avec l'argument suivant lequel les personnes mortes ne peuvent subir de préjudice parce que, n'étant plus douées de sensation, il ne peut être porté atteinte à leurs intérêts. Voir, *supra*, ch. II, section I.C. Si les nouveau-nés anencéphales ne sont, moralement parlant, pas différents des personnes décédées, pourquoi ne pas les traiter comme s'ils étaient morts ?

650. *Ibid.*

651. Pour A.L. Caplan, le fait de défendre cette conception semble équivaloir au fait de ne fonder, à tort, le respect moral que sur l'appartenance à la race humaine. *Loc. cit.*, note 632, 48. Voir également R.C. CEFALO et H.T. ENGELHARDT, *loc. cit.*, note 632, 38.

652. Voir, par exemple, B. FREEDMAN, *loc. cit.*, note 610, 57. Voir également, *supra*, ch. II, section I.B.

essentielle que les nouveau-nés anencéphales seront normalement traités de la même manière que les autres « donneurs » potentiels[653]. Rien n'empêche toutefois la médecine d'explorer les possibilités de transplantation de tissus et d'organes prélevés sur les nouveau-nés anencéphales dans le cadre des solutions fondées sur les soins habituels et sur l'élaboration de protocoles médicaux raisonnables[654].

C. Donneurs décédés et infractions contre le cadavre

Le droit pénal, en ce qui concerne les personnes décédées, protège certains intérêts et définit certains devoirs. Depuis des siècles, il impose le respect des restes humains tout en permettant à la science médicale d'obtenir les cadavres dont elle a besoin. La disposition[655] du *Code criminel* actuel interdisant à quiconque de commettre un outrage, une indécence ou une indignité envers un cadavre humain découle du reste de cette tradition. L'influence de celle-ci a déjà commencé à se faire sentir dans le contexte des prélèvements et transplantations d'organes, thérapie qui repose en grande partie sur la possibilité d'utiliser les organes de personnes qui viennent de mourir.

(1) Le don d'organes considéré comme une peine

Un médecin américain proposait récemment que les prisonniers condamnés à mort acquittent leur dette envers la société en faisant don de leurs organes au moment de leur exécution, en vue de transplantations[656]. L'idée n'est pas sans précédent historique. Au IIIe ou au IVe siècle av. J.-C., on remettait aux médecins de l'université d'Alexandrie les corps des criminels mis à mort, pour faire progresser l'anatomie[657]. On pratiquait même la vivisection sur des criminels condamnés à la peine capitale[658].

Le recours au droit pénal en vue de fournir les cadavres nécessaires pour la dissection a éventuellement gagné l'Europe et l'Amérique du Nord. En 1376, le roi Louis d'Anjou

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653. [TRADUCTION] « [I]l n'existe aucune raison valable de traiter les nouveau-nés anencéphales comme une exception qualitative en ce qui a trait aux pratiques de la transplantation. » B. FREEDMAN, *loc. cit.*, note 610, 63. Accord, COMITÉ DE BIOÉTHIQUE DE LA SOCIÉTÉ CANADIENNE DE PÉDIATRIE, « Transplantation of Organs from Newborns with Anencephaly », (1990) 142:7 *Journal de l'Association médicale canadienne* 715 ([TRADUCTION] « Les critères et les principes éthiques applicables aux transplantations d'organes mettant en cause des enfants et des adultes sont également applicables aux nouveau-nés, soit à titre de receveurs soit à titre de donneurs potentiels »).

654. Il semble que c'est la voie qui sera adoptée au Children's Hospital of Western Ontario. Voir Dahlia REICH « Organ Donations: Brain Death Guidelines to be Tested », *The London Free Press* (23 août 1989) A1.

655. L'alinéa 182*b*) du *Code criminel* est commenté *infra*, voir le texte accompagnant la note 675.

656. B.-J. C., « An Eye for an Eye » (1989), 19:2 *Hast. Cent. Rep.* 3.

657. Voir J. KEVORKIAN, *op. cit.*, note 17, pp. 20-22.

658. *Ibid.*

accordait à l'université de Montpellier la permission de recevoir chaque année le cadavre d'un criminel exécuté, pour en faire la dissection[659]. Lorsque la Guilde des barbiers-chirurgiens de Londres reçut sa charte royale en 1540, la loi unissant les deux métiers autorisait l'association à recevoir chaque année les corps de quatre criminels exécutés, à des fins de dissection et d'anatomie[660]. La loi accordait à la Guilde le droit exclusif de faire des démonstrations d'anatomie ; les barbiers-chirurgiens garderont jalousement ce privilège pendant quelque cent soixante-quinze ans[661]. Quand la pratique de l'anatomie est devenue l'apanage des chirurgiens et des médecins, on a mis à la disposition de l'association les cadavres de tous les meurtriers exécutés à Londres et dans le Middlesex[662].

Ces lois semblent avoir eu un double but. Dans certains cas, on entendait vraisemblablement aggraver la peine infligée au meurtrier en y ajoutant l'infamie de la dissection[663]. L'idée a été exprimée en 1829 par le lord juge Clerk au moment du prononcé de la peine contre William Burke, reconnu coupable du meurtre de plusieurs personnes dont il avait vendu les corps à des anatomistes écossais, et exécuté :

> [TRADUCTION]
> William Burke, vous êtes reconnu coupable, par le verdict d'un jury respectable de votre pays, du meurtre atroce dont vous avez été accusé [. . .] s'il est un cas où, hors de tout doute possible, une peine infligée par une cour criminelle sera exécutée, en tout état de cause, le vôtre l'est [. . .] Je suis disposé à accepter que votre peine soit exécutée de la manière habituelle, mais elle sera accompagnée de la peine accessoire prévue par la loi en cas de meurtre, à savoir que votre corps sera disséqué publiquement. Et j'espère, s'il devient jamais habituel de préserver les squelettes, que le vôtre le sera, de sorte que la postérité se rappelle vos crimes abominables[664].

Le chirurgien à qui Burke avait fourni bon nombre des cadavres a procédé à la dissection publique du condamné, dont on peut de nos jours voir le squelette à la faculté d'anatomie de l'Université d'Édimbourg. C'est une ironie de l'histoire que l'un des plus infâmes trafiquants de cadavres du XIX^e^ siècle ait finalement subi le châtiment prévu par les dispositions permettant la dissection des criminels exécutés pour meurtre. On retrouve cette notion de châtiment dans la récente proposition concernant l'utilisation, comme sources d'organes, des criminels exécutés aux États-Unis[665].

Le deuxième but de ces dispositions pénales était de fournir à la science médicale les cadavres dont elle avait le plus grand besoin. Il n'est pas surprenant que certains pionniers du Nouveau-Monde aient apporté avec eux cette tradition juridique. Ainsi, une loi visant

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659. A.M. LASSEK, *op. cit.*, note 15, p. 81.

660. *For Barbers and Surgeons* (R.-U.), 32 Hy. VIII, ch. 42.

661. J.M. BALL, *op. cit.*, note 19, p. 59.

662. Voir *An Act for Better Preventing the Horrid Crime of Murder*, (R.-U.), 1752, 25 Geo. II, ch. 37, abrogé par 9 Geo. IV, ch. 31, art. 99. Voir également J.M. BALL, *op. cit.*, note 19, p. 63.

663. Voir Frederick C. WAITE, « The Development of Anatomical Laws in the States of New England » (1945), 233:24 *N. Engl. J. Med.* 716, 717, où est cité le préambule de la Loi de 1752.

664. Voir D. William ROUGHEAD, *Burke and Hare*, Toronto, Canada Law Book, 1921, pp. 256-257.

665. Voir, *supra*, note 656.

à permettre la dissection des cadavres des criminels exécutés a été adoptée par la colonie de la baie du Massachusetts au milieu des années 1600[666]. L'usage a été consacré dans le droit pénal fédéral américain et est demeuré en vigueur jusqu'en 1987[667]. L'autorisation de cette pratique a également été envisagée au Canada[668], mais il n'existe aucune preuve qu'on ait donné suite à ces projets[669]. L'objectif sous-tendant l'adoption de tels textes pourrait être pertinent au regard de la pénurie actuelle d'organes au Canada, mais vu l'abolition générale de la peine de mort en 1970, cette proposition n'est pas applicable concrètement dans la société canadienne[670].

(2) Vols de cadavres, respect des restes humains

Le respect des cadavres et des restes humains est très ancien[671]. Si dans certains cas ce respect n'a pas été accordé au corps de personnes considérées comme indésirables ou exclues de la cité[672], l'attitude générale se manifeste dans les coutumes funéraires, les pratiques religieuses et les coutumes morales de la civilisation occidentale. Le droit pénal n'a pas échappé à ces influences. Dans une affaire criminelle du XIX^e^ siècle concernant le cas d'un enfant qu'on n'avait pas inhumé, un juge canadien a évoqué ces sentiments en déclarant : [TRADUCTION] « [t]out cadavre humain a droit à une inhumation décente[673]. »

De nos jours, le *Code criminel* canadien exige que les défunts soient traités avec respect. Ces dispositions témoignent du fait que l'attitude de la société, s'agissant du respect des morts, est bien ancrée dans la tradition mais connaît une certaine évolution. Elles constituent

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666. F.C. WAITE, *loc. cit.*, note 663, 717.

667. Voir 35 Stat. 1152, codifié à 18 USC 3567, abrogée par P.L. 98-473, Titre II, ch. II, al. 212(a)(1) et P.L. 99-217, art. 4, 99 Stat. 1728.

668. Voir Débats, *infra*, note 803, p. 467, n. 33, où il est question des débats relatifs à la *Loi sur l'anatomie*.

669. La première loi pénale fédérale du Canada, adoptée en 1869, prévoyait simplement que les criminels condamnés à mort devaient être exécutés « en la manière prescrite par la loi ». Leur corps devait être inhumé à l'intérieur des murs de la prison ; *Acte concernant la Procédure dans les causes criminelles ainsi que certaines autres matières relatives à la loi criminelle*, 32-33 Vict., ch. 29, art. 106, 117.

670. Voir *Loi modifiant le droit pénal (peine capitale)*, S.C. 1973-74, ch. 38, art. 2, 3 ; *Loi de 1976 modifiant le droit pénal n° 2*, S.C. 1974-75-76, ch. 105 (abolition de la peine capitale pour les infractions prévues au *Code criminel*). La peine de mort est théoriquement encore en vigueur en ce qui concerne le personnel militaire reconnu coupable de trahison ou de crimes semblables. Voir *Loi sur la défense nationale*, L.R.C. (1985), ch. N-5, notamment les art. 73, 74, 139, 203, 206.

671. Voir en général A.M. LASSEK, *op. cit.*, note 15, p. 20.

672. J. KEVORKIAN, *op. cit.*, note 17, p. 26 ([TRADUCTION] « Pour les Romains, les esclaves n'étaient pas différents des choses matérielles de leur environnement ; et la mise à mort d'un esclave n'était pas un meurtre mais simplement un dommage causé à un objet. Les esclaves et les prisonniers de guerre morts, étant souvent laissés sans sépulture, constituaient une bonne source de matériel pour les dissections pratiquées de temps à autre. »).

673. *R.* c. *Newcomb* (1898), 2 C.C.C. 255, 256 (C. comté N.-É.).

en particulier l'expression sociale de la tradition judéo-chrétienne ayant trait à l'inhumation décente des défunts, suivant laquelle le fait de ne pas accomplir ce devoir constitue une infraction, sauf excuse légitime[674].

Le *Code criminel* punit également les outrages, indécences ou indignités envers le cadavre ou les restes humains :

> Est coupable d'un acte criminel [...] quiconque [...] :
>
> *b*) commet tout outrage, indécence ou indignité envers un cadavre ou des restes humains, inhumés ou non[675].

Cette disposition vise plusieurs buts qui se recoupent. Premièrement, elle exprime la nécessité, reconnue depuis des temps immémoriaux, de respecter le cadavre de tout être humain. Deuxièmement, elle traduit également le respect des sentiments affectifs et religieux des proches parents et de la tranquillité morale de la société en général. D'un point de vue pratique, par ailleurs, la disposition vise à empêcher les outrages envers le cadavre, à protéger la santé publique et à combattre les nuisances publiques. L'examen de l'héritage de la common law au Canada, en Grande-Bretagne et aux États-Unis montre comment les tribunaux ont tenu compte de ces objectifs dans des causes relatives à la vente de parties du corps, à l'indécence sexuelle, au vol et même dans le contexte plus moderne de l'expérimentation médicale.

C'est traditionnellement sur le souci de préserver l'intégrité morale de la collectivité que l'on a fait reposer la définition des actes criminels envers les cadavre ou les restes humains. Les plus grands juristes britanniques et penseurs européens du XVIII^e^ et du XIX^e^ siècles considéraient l'outrage à la dépouille comme une grave infraction morale[676]. L'infraction figurant dans le code canadien découle directement du projet de code pénal britannique de 1879, jamais adopté, qui pour l'essentiel reprenait les règles dégagées par la common law britannique en ce qui concerne les infractions contre les cadavres[677]. Si

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674. *Code criminel*, al. 182*a*). La Commission a proposé d'abroger les dispositions relatives à l'inhumation en raison de leur caractère archaïque. Voir Rapport n° 31, *op. cit.*, note 116, p. 116.

675. *Code criminel*, al. 182*b*).

676. Voir, James Fitzjames STEPHEN, *A Digest of the Criminal Law: Crimes and Punishments*, 4^e^ éd. Londres, Macmillan, 1887, art. 175 (infraction relative à la morale) ; William BLACKSTONE, *Commentaries on the Laws of England. Book the Fourth*, Oxford, Clarendon Press, 1779, p. 236. Comparer la *Criminal Code Act* de 1983, du Northern Territory of Australia, art. 140 (la mauvaise conduite envers un cadavre est une infraction morale) ; *New Zealand Crimes Act, 1961*, art. 150 (crimes contre les restes humains et crimes contre la personne) ; et les crimes contre les sépultures, art. 360 du Code pénal de la France. Comme il s'agit d'une infraction relative à la morale, l'art. 360 a été interprété d'une manière large, de sorte qu'il vise les monuments funéraires, les cadavres inhumés et les cadavres non encore inhumés, *Code pénal*, 88^e^ éd., Paris, Dalloz, 1991. Voir R. DIEBKENS, *op. cit.*, note 382, par. 311. À cet égard, voir également les observations sur l'application possible des textes français portant sur les voies de fait et les coups et blessures, *infra*, note 717.

677. Voir GRANDE-BRETAGNE, CRIMINAL CODE BILL COMMISSION, *Report of the Royal Commission Appointed to Consider the Law Relating to Indictable Offences*, Londres, HMSO, 1879, p. 22, ([TRADUCTION] « [...] les articles 153 et 158 exposent les règles de la common law [...] » ; J.F. STEPHEN, *op. cit.*, note 676, pp. 117, 122 ; *Code criminel, 1892*, 55-56 Vict., ch. 29, art. 206. Pour une description générale des cent premières années du *Code criminel* canadien, voir A.W. MEWETT, « The Criminal Law, 1867-1967 » (1967), *R. du B. can.* 726.

la volonté d'interdire les actes tenant de la nécrophilie[678] est le fondement moral le plus évident du texte actuel, c'est en fait à cause des problèmes suscités par les besoins de la science médicale en cadavres humains que le crime a été établi en common law[679]. Dans la cause datant de 1788 où la règle a été établie, un homme a été condamné à une amende de cinq *marks* pour avoir exhumé un cadavre qu'il entendait vendre à un médecin voulant faire une dissection anatomique[680]. À cause de la très ancienne règle selon laquelle le corps humain n'est pas susceptible d'appropriation, l'homme ne pouvait être reconnu coupable de vol de cadavre[681]. Le tribunal a également estimé que le fait d'exhumer un cadavre en vue d'une dissection ne constituait pas d'une manière expresse une infraction à une loi interdisant d'exhumer les morts pour la pratique de la sorcellerie[682]. Il a tout de même conclu que l'acte commis était très indécent, était contraire aux bonnes mœurs et constituait de ce fait une infraction criminelle. Cette affaire montre que la common law, pour combattre la vente des cadavres, allait emprunter la voie des infractions du type « actes indécents, outrages », plutôt que celle, plus directe, de l'infraction de vol. Sauf l'exception historique que constitue l'infraction de vol d'ossements dans les sépultures indiennes[683], le législateur canadien semble avoir maintenu cette tradition en adoptant l'alinéa 182*b*) du *Code criminel*.

Avant l'adoption du *Code criminel* canadien, les tribunaux britanniques étendaient la portée du crime prévu en common law aux médecins qui acceptaient des cadavres qu'ils savaient avoir été illégalement exhumés[684]. On semble avoir fait de même au Canada au milieu du XIX^e^ siècle, avant l'adoption du *Code criminel* canadien. Les professeurs de médecine qui payaient entre 30 $ et 50 $ pour les cadavres provenant des cimetières locaux étaient condamnés à une amende de 50 $ pour avoir commis une « infraction contre la décence[685] ». Ces pratiques commerciales entraînaient apparemment des peines plus sévères aux États-Unis ; un entrepreneur de pompes funèbres a par exemple été condamné en 1900 à une amende de 750 $ et à une peine d'emprisonnement de onze mois pour avoir vendu des cadavres à des médecins voulant pratiquer des dissections[686]. Il ressort de ces affaires[687] — et du fondement juridique historique de l'infraction énoncée au code actuel —

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678. *R.* c. *Ladue*, [1965] 4 C.C.C. 264 (C.A. T.Y.).

679. Comparer « W. German Universities Spark Furor Over Using Remains of Nazi Victims », *The [Toronto] Globe and Mail* (12 janvier 1989) A12.

680. *R.* c. *Lynn* (1788), 100 E.R. 394.

681. Voir *supra*, section I.A. Voir également A.T.H. SMITH, « Stealing the Body and Its Parts » [1976], *Crim. L. Rev.* 622.

682. Voir *Lynn*, précité, note 680, discutant de la *Witchcraft Act of 1735*.

683. Voir *Acte du larcin*, S.R.C. 1886, ch. 164, art. 98, intégré au *Code criminel*, S.R.C. 1927, ch. 36, art. 385, abrogé par *Code criminel*, S.C. 1953-54, ch. 51, art. 745.

684. Voir *R.* c. *Cundick* (1822) ; *R.* c. *Davies* (1828) (assises de Lancaster), description dans *Select Committee on Anatomy*, *op. cit.*, note 22, pp. 6, 7.

685. Voir *infra*, le texte accompagnant la note 809.

686. Voir *Thompson* c. *State*, 58 S.W. 213 (Tenn. 1900).

687. Pour des décisions plus récentes concernant la vente de cadavres, voir *People* c. *Bullington*, 80 P. 2d 1030 (Cal. 1938) et *Commonwealth of Pennsylvania* c. *Spector* (28 octobre 1988), Philadelphia 87-01-2441-2445 (Court of Common Pleas). Voir également, *infra*, note 694.

que la vente de restes humains ou de cadavres est peut-être toujours visée par le texte d'incrimination en question[688]. Dans la mesure où la vente de cadavres humains, de parties du corps et de tissus corporels continue à être perçue comme portant atteinte à l'intégrité et à la dignité fondamentales de l'être humain[689], ce texte concrétise le sentiment général selon lequel le respect s'impose à l'égard du cadavre humain.

Une telle infraction témoigne par ailleurs du souci de protéger l'hygiène publique et de lutter contre les nuisances. Le fait de laisser des cadavres dans des endroits publics ou de les jeter dans les cours d'eau est en effet susceptible d'exposer le public à des maladies ou de contaminer l'eau et est jugé inacceptable pour cette raison[690]. Une telle conduite pourrait également causer des problèmes d'ordre matériel et indisposer le public. Du reste, c'est toujours à la rubrique « nuisances » qu'ont été classées les infractions relatives aux cadavres, dans le *Code criminel* canadien[691].

Outre qu'elles protègent les intérêts et ménagent la sensibilité de la collectivité, les règles du droit pénal interdisant les outrages à l'égard des cadavres encouragent une conduite physique respectueuse envers le défunt. Elles assurent la protection de l'intégrité corporelle d'êtres réputés dignes de respect mais incapables de se protéger eux-mêmes. Voici un exemple. Dans certains États américains, on considère comme un acte criminel le fait de mutiler un cadavre ou de commettre un outrage à son égard[692]. Les dispositions en cause interdisent le défigurement illégal et inutile ainsi que tout atteinte à l'intégrité des cadavres[693]. Elles ont récemment été invoquées dans une poursuite intentée contre un médecin, une maison funéraire et les employés de la morgue d'un hôpital, pour mutilation ou atteinte à l'intégrité de cadavres et trafic de parties du corps humain[694].

Enfin, les textes en question protègent les intérêts affectifs et religieux des proches parents, qui peuvent s'opposer radicalement à toute atteinte au corps du défunt[695]. Ces

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688. Voir l'art. 182 du *Code Criminel*, dans le texte accompagnant la note 675, *supra*.

689. Voir *supra*, section I.C et ch. II, section IV.B.

690. Voir *R.* c. *Clark* (1883), 15 Cox C.C. 171 ; *State* c. *Hartzler*, 433 P. 2d 231 (N.M. 1967) ; *Kanavan's Case*, 1 Me. 226 (1821).

691. Comparer J.F. STEPHEN, *op. cit.*, note 676, pp. 117, 122.

692. Voir, par exemple, *California Health & Safety Code*, art. 7052 (West 1988 Supp.) (mutilation d'un cadavre considérée comme une infraction criminelle). Voir également *Pennsylvania Cons. Stat. Ann.*, art. 5510 (Purden 1990 Supp.) (outrage à l'égard d'un cadavre).

693. Voir *Bullington*, précité, note 687 (l'extraction de deux couronnes en or, sans mutilation du corps ni des dents, ne constitue pas une mutilation criminelle d'un cadavre).

694. Voir *Spector*, précité, note 687 (médecin condamné à une amende de 35 000 $ et à 16 000 heures de services médicaux dans des prisons municipales pour avoir vendu pendant 15 ans à des centres de recherches médicales des parties du corps obtenues de la morgue d'un hôpital universitaire). Voir également *People of California* c. *Sconce* (24 mai 1988), Los Angeles A5732891 (Sup. Ct) ; « Reward Offered in Case Against Mortician », *New York Times* (8 juin 1989) A16 (employé d'un salon funéraire condamné à 5 ans de prison relativement à 21 chefs d'accusation, dont celui d'avoir mutilé volontairement des restes humains et enlevé des parties du corps, dans le but présumé de les vendre à des facultés de médecine). Voir également *infra*, note 717.

695. Voir *Kohn*, précité, note 404.

intérêts peuvent être violés par des atteintes à l'intégrité physique, des mutilations, des actes d'indécence sexuelle ou d'autres conduites du même genre qui outrageraient les sentiments familiaux normaux[696]. En ce sens, les protections établies par le droit pénal s'accordent avec les intérêts familiaux reconnus par la common law et le droit civil, et les renforcent[697].

À de nombreux égards, donc, l'infraction relative aux cadavres qui figure actuellement au *Code criminel* traduit l'existence de valeurs constantes et fondamentales à l'égard de la mort et de la dignité humaine. Ce texte, dans la pratique, contribue à la protection des divers intérêts sociaux en cause. Il exige le simple respect du cadavre humain ; il encourage à tenir compte de la sensibilité et des intérêts affectifs des membres de la famille ; il aide à empêcher les nuisances publiques ; il s'oppose au défigurement, à la mutilation et à toute atteinte illégale et inutile à l'intégrité du cadavre. D'un point de vue historique, la préoccupation morale ayant trait à l'indécence concernait à la fois les actes relevant de la nécrophilie et la vente des cadavres.

Dans la mesure où les préoccupations dont nous venons de faire état — et auxquelles l'infraction prévue au *Code criminel* répondait à l'origine — sont plus directement et plus clairement régies par des textes modernes, il est peut-être souhaitable de modifier la définition de cette infraction. Les devoirs relatifs à l'inhumation, le souci de l'hygiène publique et de la lutte contre les nuisances, les mécanismes suivant lesquels la science médicale peut obtenir les cadavres dont elle a besoin — toutes ces questions sont désormais régies par des lois provinciales concernant l'anatomie, l'hygiène publique et les cimetières[698]. Le trafic de cadavres pourrait sans doute également être régi, au moins en partie, par des textes relatifs à la vente[699]. Même alors, cependant, l'infraction conserverait son utilité, en ce qu'elle encourage les citoyens à se conduire d'une manière respectueuse à l'endroit des cadavres, et s'oppose aux atteintes à l'intégrité corporelle ainsi qu'aux préjudices moraux. En effet, si la mutilation, la profanation, les agressions sexuelles ou tout acte répréhensible à l'égard d'un cadavres ou des restes humains portent atteinte à l'intégrité corporelle du défunt, ils portent également atteinte à la dignité de ce dernier, aux valeurs humaines ainsi qu'aux valeurs morales fondamentales.

Enfin, lorsqu'on cherche à savoir comment et pourquoi l'infraction qui nous intéresse a depuis toujours rempli la fonction de dispositions qui auraient normalement pu être fondées sur les notions de vente et de vol, on constate inévitablement qu'une ambiguïté notable

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696. Voir AMERICAN LAW INSTITUTE, *Model Penal Code and Commentaries : Part II*, Philadelphie (Pa.), The Institute, 1980, art. 250.10, commentaire 2, pp. 420-421 (Exploitation des cadavres : [TRADUCTION] « Sauf dans la mesure où la loi l'autorise, commet une infraction quiconque traite un cadavre d'une manière susceptible de heurter la sensibilité normale d'une famille »).

697. Voir, *supra*, le texte accompagnant les notes 386 à 395. Voir en général John S. HERBRAND, « Validity, Construction, and Application of Statutes Making It a Criminal Offense to Mistreat or Wrongfully Dispose of Dead Body », 81 A.L.R. 3d 1071.

698. Voir, par exemple, Alta. Reg. 298/86 ; O.C. 82/18 A. Gaz. 1918.II.991 ; *Cemeteries Act*, R.S.O. 1980, ch. 59. Voir également *infra*, section III.B(1).

699. Voir *infra*, section III.B.

s'est perpétuée au fil des siècles. Les squelettes et les spécimens anatomiques préparés à partir des parties de cadavres, ou qui proviennent de corps humains, peuvent-ils, en droit, faire l'objet d'un vol ? Les plus grands juristes britanniques et canadiens se posent la question depuis le XIX[e] siècle[700]. Le fondement historique de l'infraction pourrait à première vue nous amener à conclure que même des restes humains ayant été légalement prélevés, puis transformés par le savoir-faire et le travail de spécialistes en momies ou en spécimens d'anatomie, ou d'autres tissus humains traités et préservés de façon similaire, ne sont nullement protégés à l'heure actuelle par les dispositions du droit pénal interdisant le vol : ce qui n'est pas susceptible d'appropriation ne pourrait être volé[701]. Du reste, la logique du principe de common law vieux de trois cents ans voulant que le vol d'un cadavre soit une chose impossible (seul le linceul pouvant être dérobé[702]) semblerait de la même façon mener à la conclusion qu'il n'est pas possible de voler un squelette de laboratoire, mais seulement le fil qui maintient les parties en place[703], ni de voler des substances corporelles, mais uniquement les fioles ou les éprouvettes qui les contiennent[704]. Mais de nos jours, cette conclusion semble contraire au bon sens, aux valeurs fondamentales du droit pénal et à la conception élargie de la propriété, suivant laquelle les dispositions relatives au vol s'appliquent à diverses choses qui auparavant n'étaient pas tenues pour des biens susceptibles d'appropriation : choses animées ou inanimées, services de télécommunication, animaux sauvages, voire électricité[705].

(3) Respect dû aux personnes qui viennent de mourir

Un grand nombre des problèmes concernant le respect des morts, les souhaits et les croyances de la famille, ce qui est jugé acceptable par la collectivité, se posent tous ensemble dans le cas d'une nouvelle catégorie de patients : ceux qui sont en état de mort cérébrale[706]. La médecine moderne est en mesure de maintenir en « vie » ces personnes

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700. Comparer J.F. STEPHEN, *op. cit.*, note 676, art. 292, G.W. BURBIDGE, *Digest of the Criminal Law of Canada: Founded by Permission on Sir James Fitzjames Stephen's Digest of the Criminal Law*, Toronto, Carswell, 1890, pp. 284, 288 (choses non susceptibles d'être volées) et P. MATTHEWS, *loc. cit.*, note 385, 219-220.

701. *Ibid.* Comparer *Doodward* c. *Spence* (1907), 7 S.R. 727 (N.S.W. Austr.) (même si l'on ne peut être propriétaire d'un cadavre, des droits de possession susceptibles de protection peuvent être établis si, par son savoir-faire et son travail, on modifie sensiblement l'état du corps) ; J.W. Cecil TURNER (dir.), *Kenny's Outlines of Criminal Law*, 19[e] éd., Cambridge, Cambridge University Press, 1966, pp. 294-295 ([TRADUCTION] « Il n'est pas entièrement certain que la règle soit " cadavre un jour, cadavre toujours " ; le cas échéant, la protection du droit pénal pourrait peut-être ne pas s'étendre aux squelettes et aux autres produits anatomiques ayant nécessité beaucoup de travail ni aux collections ethnologiques de crânes ou de momies — cela semblerait en effet déraisonnable. ») ; J.C. SMITH et Brian HOGAN, *Criminal Law*, Londres, Butterworths, 1983, pp. 490-491.

702. Voir l'affaire *Haynes*, précitée, note 384.

703. P.D.G. SKEGG, *loc. cit.*, note 412, 417-418, n. 35, 39.

704. Voir *R.* c. *Welsh*, [1974] R.T.R. 478 (C.A.) (échantillon d'urine) et *R.* c. *Rothery*, [1976] R.T.R. 550 (C.A.) (échantillon de sang).

705. Voir Rapport n° 31, *op. cit.*, note 116, ch. 1(2) ; *Code criminel*, art. 322.

706. Voir S.J. YOUNGER et autres, *loc. cit.*, note 266, 323.

pendant des heures ou des jours, en vue de la transplantation d'organes, voire pendant des semaines ou des mois, dans le cas d'une femme enceinte, pour que l'enfant puisse venir au monde[707].

Qu'est-ce qui, dans ce contexte, pourrait être considéré comme une atteinte à l'intégrité du cadavre[708] ? La question demeure épineuse, parce qu'il est difficile de caractériser sur le plan moral la situation de ces personnes. Devrait-on les traiter comme des cadavres, des « patients décédés[709] » ou des cadavres qui respirent et dont le cœur bat[710], bien que suivant les critères traditionnels il soit difficile de déterminer si elles sont vivantes ou mortes ? À quelles conditions, le cas échéant, est-il acceptable de pratiquer sur ces patients des techniques à des fins de formation, de recherches ou d'expérience médicales ? Les dispositions du *Code criminel* relatives au cadavre rendent-elles nécessaire l'obtention d'un consentement avant que de telles interventions puissent être effectuées ? Il s'agit là de questions fascinantes et troublantes, qui en outre débordent les limites du droit pénal au sens strict du terme. Il ressort des articles qui y sont consacrés que, dans une large mesure, les réponses sont fonction de l'attitude adoptée à l'égard de deux autres problèmes : À quel respect et à quelle dignité le patient qui vient de mourir a-t-il droit ? Quels sont les avantages que présente pour la médecine l'utilisation du corps de ces patients ?

Les patients qui viennent de mourir peuvent faire progresser la science médicale, le traitement et la formation. Lorsqu'une personne meurt d'une crise cardiaque dans la salle d'urgence d'un hôpital, cela peut donner aux étudiants en médecine l'occasion de pratiquer les techniques de réanimation, d'administration de médicaments[711] ou d'intubation[712]. On justifie ces pratiques en faisant valoir qu'elles sont efficaces au point de vue didactique, que la santé et la sécurité des citoyens sont favorisées par la formation médicale donnée au moyen de « non-personnes » qu'il faut seulement, par respect, éviter de défigurer ou de ridiculiser[713]. On offre des arguments semblables pour justifier la recherche médicale et l'expérimentation sur les cadavres, du simple prélèvement d'échantillons de sang[714] aux essais relatifs à l'anesthésie pour la transplantation d'organes, aux respirateurs[715] et

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707. Voir David R. FIELD et autres, « Maternal Brain Death During Pregnancy » (1988), 260:6 *JAMA* 816 (cas d'une femme en état de mort cérébrale qu'on a gardée branchée à un respirateur pendant neuf semaines au coût de 214 784 $ afin de permettre la naissance d'un enfant de sexe masculin). Voir en général Note, « Incubating for the State: The Precarious Autonomy of Persistently Vegetative and Brain-Dead Pregnant Women » (1988), 22 *Ga L. Rev.* 1103.

708. Voir *Code criminel*, al. 182*b*), cité dans le texte qui accompagne la note 675, *supra*.

709. S.J. YOUNGER et autres, *loc. cit.*, note 266, 323.

710. Robert M. VEATCH, *The Patient as Partner*, Bloomington, Indiana University Press, 1987, p. 190 ; D.R. FIELD et autres, *loc. cit.*, note 707, 818-819.

711. Voir Kenneth V. ISERSON et Charles M. CULVER, « Using a Cadaver to Practice and Teach » (1986), 16:3 *Hast. Cent. Rep.* 28.

712. J.P. ORLOWSKI, G.A. KANOTI et M.J. MEHLMAN, *loc. cit.*, note 279 et (1989) 320:6 *N. Engl. J. Med.* 396-397 (lettres).

713. J.P. ORLOWSKI, G.A. KANOTI et M.J. MEHLMAN, *loc. cit.*, note 279, 440-441.

714. Barry S. COLLER et autres, « Inhibition of Human Platelet Function *In Vivo* with a Monoclonal Antibody: With Observations on the Newly Dead as Experimental Subjects » (1988), 109:8 *Ann. Intern. Med.* 635.

715. R.M. VEATCH, *op. cit.*, note 710.

aux cœurs[716] artificiels. Au cours des procédures judiciaires et du débat public relatifs à des accusations criminelles portées à la suite d'expériences réalisées sur un homme en état de mort cérébrale, qui avait été hospitalisé après avoir perdu la vie dans un accident d'automobile en France, on a ainsi fait valoir que la science médicale ne pourrait progresser sans la recherche clinique et l'expérimentation[717].

Les avantages médicaux et sociaux découlant de l'utilisation des patients qui viennent de mourir doivent être évalués en regard des préoccupations relatives au respect dû aux morts et à la signification de l'intégrité corporelle du cadavre. Au cours du débat sur le cas qui vient d'être évoqué, le Comité Consultatif National d'Éthique français a réclamé la primauté du respect de la personne et de ses restes ; le président de la République a emboîté le pas en demandant à la société de ne jamais oublier que l'être humain n'est pas un instrument[718]. Ces observations semblent découler d'une conception suivant laquelle on accorde un grand respect aux morts parce qu'on attache au corps une dignité et un caractère humain qui relèvent du symbole. Les tenants de ce point de vue tendent à considérer le corps d'une personne qui est morte, mais qui respire et dont le cœur bat, comme une personne plutôt que comme un cadavre[719].

Ce qui ressort de ces diverses considérations — avantages médicaux, possibilité d'atteinte à l'intégrité corporelle, respect des morts , c'est un désaccord quant à l'opportunité d'exiger l'obtention d'un consentement afin de tenir compte des intérêts divergents en jeu. Les techniques utilisées à des fins d'expérimentation et de formation médicale n'ont pas nécessairement pour effet de défigurer ou de mutiler le corps du patient qui vient de mourir ni de porter atteinte de quelque façon à son intégrité corporelle. Toutefois, la simple intubation pourra être considérée comme une indignité ou un acte abusif par la famille dont on n'a pas demandé le consentement, et qui s'oppose à l'utilisation de telles techniques pour des raisons religieuses ou parce qu'elle les juge outrageantes[720].

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716. Voir Susan R. MARTYN, « Using the Brain Dead for Medical Research » (1986), *Utah L. Rev.* 1, 7, n. 37.

717. Voir « L'expérimentation sur les comateux », *Le Monde* (21 décembre 1988) 22. Voir également D. DICKSON, « Human Experiment Roils French Medicine » (1988), 239:4846 *Science* 1370. On aurait porté des accusations de voies de fait, en vertu de l'article 309 du Code pénal, pour « coups et blessures volontaires sur une personne hors d'état de se protéger elle-même, en raison de son état physique ou mental », *Code pénal*, *op. cit.*, note 676 ; Jean-Yves NAU, « Un texte sur les comas dépassés est à l'étude », *Le Monde* (8 mars 1988) 12.

718. « L'être humain n'est pas un instrument », *Le Monde* (27 février 1988) 17. Voir COMITÉ CONSULTATIF NATIONAL D'ÉTHIQUE POUR LES SCIENCES DE LA VIE ET DE LA SANTÉ, *Avis sur l'expérimentation médicale et scientifique sur des sujets en état de mort cérébrale* (7 novembre 1988), dans *Éthique et recherche biomédicale : rapport 1988*, Paris, La Documentation française, 1989, p. 23 [ci-après Comité]. Voir également Frank NOUCHI, « Les expérimentations en cas de mort cérébrale autorisées sur les patients ayant fait don de leur corps à la science », *Le Monde* (8 novembre 1988) 32.

719. Voir *supra*, ch. II, sections I.C et IV. Voir également John LA PUMA, « Discovery and Disquiet: Research on the Brain-Dead » (1988), 109:8 *Ann. Intern. Med.* 606, 607 (la dignité humaine du corps ne devrait jamais être violée, même dans la poursuite de la connaissance scientifique la plus précieuse).

720. Comparer AMERICAN LAW INSTITUTE, *op. cit.*, note 696, J.P. ORLOWSKI, G.A. KANOTI et M.J. MEHLMAN, *loc. cit.*, note 279, 441 et *Strachan*, précité, note 394, 351 (en refusant d'accéder à la demande des membres de la famille, qui souhaitaient se voir remettre le corps de leur fils, l'hôpital avait porté atteinte à la dignité et à l'autonomie des intéressés et leur avait infligé une peine inutile).

Les médecins souhaitant utiliser un cadavre à des fins d'expérimentation ou de formation devraient-ils être tenus d'obtenir un consentement, ou y aurait-il lieu, au contraire, d'établir une présomption de consentement dans des limites raisonnables ? D'une part, il ne semble pas exister beaucoup de solutions satisfaisantes. Demander le consentement des membres de la famille peut sembler compliqué, inhumain, et cela risque de prendre beaucoup de temps. En outre, les interventions en cause, qui ne portent pas véritablement atteinte à l'intégrité corporelle, répondent au souci de favoriser la santé et la sécurité de la population. Tous ces éléments justifieraient, selon certains auteurs, une politique fondée sur une présomption de consentement, sauf en cas d'opposition manifeste de la part du défunt ou de ses proches parents[721].

D'autre part, d'autres considérations plaident en faveur d'une plus grande rigueur en matière de consentement. Premièrement, le médecin qui agit sans demander le consentement des proches parents risque de porter atteinte à leurs croyances religieuses et morales, ou à leurs simples préférences. Une telle attitude semble incompatible avec les attentes normales d'une famille affligée. En effet, même la signature d'un formulaire hospitalier de consentement général[722] ne répondrait vraisemblablement pas aux attentes normales du patient ou de ses proches, en ce qui a trait au sort réservé au corps après la constatation du décès. C'est pourquoi certains auteurs font valoir que la présomption de consentement repose sur une duperie injustifiée, susceptible de miner la confiance entre le médecin et son patient, entre l'hôpital et la collectivité qu'il sert[723].

Deuxièmement, on pourrait estimer que le fait de ne pas informer la famille des interventions pratiquées contrevient au devoir général de loyauté que le médecin a envers son patient[724]. Celui-ci confie son corps à son médecin, lui accorde sa confiance, avec la conviction qu'il agira avec toute la compétence dont il est capable et pour le seul bien de son patient. Or, les interventions pratiquées sans qu'on se soit enquis de la volonté exprimée par le patient ou des souhaits de ses proches parents battent en brèche ce climat de confiance, cette notion de loyauté. Le caractère unilatéral de la décision dont elles découlent risque de déconsidérer ou de trahir les intérêts, les droits et la confiance de personnes qui sont profondément touchées. De ce point de vue, la mort ne transforme pas la possession légitime d'un patient pour l'application d'un traitement en un droit d'intervenir sur son corps, après son décès, à des fins non thérapeutiques.

Troisièmement, même si dans certains cas la présomption de consentement peut être justifiée en raison des bienfaits manifestes que présente l'utilisation par la science médicale du corps du patient qui vient de mourir, les avantages pouvant être tirés au chapitre de la formation et de la recherche médicales sont nettement moins immédiats et moins tangibles[725]. La présomption de consentement pourrait par exemple être tenue pour légitime lorsqu'on souhaite effectuer une transplantation d'organes ou de tissus, parce que

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721. J.P. Orlowski, G.A. Kanoti et M.J. Mehlman, *loc. cit.*, note 279, 441.

722. Voir E.I. Picard, *op. cit.*, note 364, 43.

723. Voir K.V. Iserson et C.M. Culver, *loc. cit.*, note 711, 29 (le commentaire de Culver).

724. Voir, *supra*, le texte accompagnant la note 445.

725. Voir J. La Puma, *loc. cit.*, note 719, 607.

le prélèvement a un effet favorable immédiat, probable et caractérisé : il permet de sauver des vies ou de guérir des malades[726]. Mais les avantages que procure la thérapie directe ne peuvent être mis sur le même pied, du point de vue moral, que ceux qui découlent de la recherche et de la formation[727]. C'est la conclusion à laquelle est arrivé le Comité d'éthique français en refusant d'appliquer à l'expérimentation sur les personnes en état de mort cérébrale les dispositions de la loi sur la transplantation de tissus humains qui établissent une présomption de consentement[728]. Le Comité recommandait que de telles expériences ne soient effectuées que si le patient a légué, par écrit, son corps à la science[729].

Enfin, l'établissement d'une présomption de consentement concernant l'utilisation, à des fins médicales ou pour faire des expériences, du corps des patients en état de mort cérébrale semble contraire à l'éthique médico-juridique canadienne. Bien que cela ne soit pas un critère déterminant, la politique établie par les autorités consacre souvent les valeurs fondamentales qui animent le droit pénal[730]. Les lois régissant l'anatomie et le don de tissus[731] ainsi que les lignes directrices en matière d'expérimentation médicale[732] qui pourraient être applicables aux interventions sur les patients en état de mort cérébrale[733] font en général reposer sur la notion de consentement le don d'un corps humain à la science, ce consentement pouvant être donné par le patient lui-même ou par ses proches parents. Ces règles découlent quant à elles des principes de common law suivant lesquels les exécuteurs et la famille de la personne décédée ont une sorte de droit de possession sur la dépouille[734].

Il semblerait donc que les circonstances médicales et les avantages qu'est susceptible de procurer l'utilisation du corps des patients qui viennent de mourir ne sont ni uniques ni irrésistibles, et partant ne sauraient justifier une exception aux règles habituelles en matière de consentement — à moins que des textes autorisent sans équivoque de telles interventions. Normalement, c'est à la famille que le consentement est demandé. Le fait d'exiger l'obtention d'un consentement semble un moyen commode de tenir compte, à la fois, des besoins grandissants de la médecine et des préoccupations du droit pénal et

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726. Voir *infra*, note 842.

727. Voir J. La Puma, *loc. cit.*, note 719, 407.

728. Voir Comité, *op. cit.*, note 718.

729. *Ibid.*

730. Voir CRD, *Notre droit pénal*, Rapport n° 3, Ottawa, Approvisionnements et Services Canada, 1976, pp. 5-9.

731. Voir *infra*, section III.B.

732. Voir Document de travail n° 61, *op. cit.*, note 295.

733. Voir M.A. Somerville, *op. cit.*, note 369, p. 78 (l'expérimentation médicale sur les cadavres pourrait être visée par les dispositions portant sur « l'objectif thérapeutique, l'enseignement médical ou la recherche scientifique » qui figurent dans les lois provinciales sur le don de tissus) ; President's Commission, *Implementing Human Research Regulations*, Washington (D.C.), la Commission, 1983, pp. 39, 41 (où l'on recommande que les comité d'éthique sur la recherche se penchent sur l'expérimentation sur les cadavres).

734. Voir, *supra*, section I.

de la morale au sujet du respect à l'égard des morts, des intérêts de la famille et de ceux de la collectivité. Des précisions pourraient être apportées par le législateur[735] et les établissements hospitaliers quant aux modalités de ce consentement.

Dans cette perspective, la preuve d'un consentement valable à l'intervention médicale soulèverait une présomption de légalité au regard de l'infraction relative aux outrages envers un cadavres. Les difficultés qui se posent concernent notamment le moment où la demande est faite et la façon dont elle est présentée. La chose est en effet très délicate, comme en témoigne la citation suivante, qui a trait aux expériences faites sur les enfants en état de mort cérébrale :

> [TRADUCTION]
> Il serait essentiel que l'expérience respecte le corps maintenu en vie par des moyens mécaniques et le souvenir que les parents ont de la personne qui était (qui demeure — la mort n'est pas « la fin » pour les parents) leur enfant. Ce qui comptera sans doute le plus, ce sera l'attitude et le ton de voix de la personne chargée de demander aux parents leur consentement. Si elle se souvient qu'il s'agit d'une supplication à propos d'une chose précieuse, et si elle en tient compte dans la formulation de la demande, il n'y a aucune raison de ne pas présenter celle-ci. La décision appartient aux parents[736].

Le problème consiste à savoir de quelle façon et à quel moment la demande devrait être présentée.

La confiance et la loyauté qui forment depuis longtemps le fondement de la relation entre le médecin et son patient sembleraient donc imposer des devoirs spéciaux aux professionnels de la santé, aux patients et à leur famille. Il incombe sans doute aux médecins et aux hôpitaux de mettre au point des mécanismes qui permettront de demander le consentement avec toute la compassion qui s'impose dans ces circonstances délicates, mécanismes qui devront être régulièrement revus et améliorés. Quant aux consommateurs de soins de santé, qui deviendront des patients tôt ou tard, ils ont peut-être le devoir moral de réfléchir à la possibilité de donner leur corps à la science, et d'en parler. On peut de toute évidence faire un parallèle avec le système de dons d'organes volontaires. Le recours aux patients en état de mort cérébrale en vue de la formation et de la recherche médicales semblerait acceptable [TRADUCTION] « lorsqu'il répond à un objectif social important, lorsque le consentement d'une personne compétente [un membre de la famille, par exemple] est obtenu et lorsqu'on tente, en pratiquant l'intervention, d'éviter la profanation et de préserver le respect dû au corps humain[737] ».

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735. Voir Document de travail n° 61, *op. cit.*, note 295, p. 13 (loi fédérale sur l'expérimentation sur des sujets humains).

736. R.M. VEATCH, *op. cit.*, note 710, p. 192, citant R.A. CARSON, J.L. FRIAS et R.J. MELKER, « Research with Brain-Dead Children » (1981), 3:1 *IRB : Rev. Human Subjects Res.* 5.

737. Norman FOST, « Research on the Brain Dead » (1980), 96:1 *J. Pediatr.* 54, 56. Accord K.V. ISERSON et C.M. CULVER, *loc. cit.*, note 711, 29 (commentaire de Culver) ; B.S. COLLER et autres, *loc. cit.*, note 714, 638 ; Comité, *op. cit.*, note 718 ; R.M. VEATCH, *op. cit.*, note 710, p. 190. Voir cependant J.P. ORLOWSKI, G.A. KANOTI et M.J. MEHLMAN, *loc. cit.*, note 279, 441 et K.V. ISERSON et C.M. CULVER, *loc. cit.*, note 711 (commentaire d'Iserson).

III. Législation fédérale et provinciale

Depuis plus d'un siècle, les gouvernements fédéral et provinciaux se partagent la compétence législative pour la réglementation du prélèvement et de l'utilisation des tissus humains. En plus de l'élaboration des textes d'incrimination figurant au *Code criminel*, le Parlement fédéral est chargé de veiller à la sécurité et à l'efficacité des techniques de remplacement des tissus humains au moyen de la *Loi sur les aliments et drogues*[738]. D'autres lois, notamment celles relatives à la quarantaine, aux douanes, à l'immigration, à l'impôt sur le revenu et à la santé, confient au gouvernement fédéral, au nom de tous les Canadiens, diverses fonctions et responsabilités publiques qui ont une incidence sur les problèmes que suscite le don de tissus humains. À l'échelon provincial, les lois sur l'anatomie, sur la cornée et sur le don de tissus ont fortement contribué à l'établissement des règles applicables au Canada en la matière.

A. Législation fédérale

(1) Textes sur les médicaments et les instruments médicaux

La *Loi sur les aliments et drogues* (LAD) vise à assurer la sécurité et l'efficacité des médicaments ou des instruments médicaux en usage au Canada. Cette loi, dont l'application relève de Santé et Bien-être social Canada, est fondée sur la compétence législative du gouvernement fédéral en matière de droit criminel[739]. Son adoption répondait au souci d'interdire ou de réglementer la fabrication ou la vente d'aliments, de médicaments, d'appareils médicaux ou autres produits semblables falsifiés ou mal étiquetés, susceptibles de causer un préjudice à la santé du public ou à sa sécurité[740]. Les cosmétiques et les appareils médicaux sont régis par cette loi depuis 1939[741]. Le fait que les appareils médicaux et les médicaments soient destinés à être utilisés à des fins thérapeutiques (et, dans le cas des médicaments, à être dans bien des cas administrés de façon interne), pour le traitement de maladies et de blessures, semble nécessiter des contrôles plus sévères que dans le cas des cosmétiques :

> [TRADUCTION]
> Il est évident [. . .] qu'à mesure que s'accroissent les risques pour la santé suscités par les médicaments, que ce soit en raison de leurs ingrédients ou des propriétés qu'on leur attribue, il faut, dans l'intérêt des consommateurs, exercer des contrôles plus systématiques et plus sévères que dans le cas des aliments ou des cosmétiques[742].

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738. L.R.C. (1985), ch. F-27 [ci-après LAD].

739. Voir *R.* c. *Wetmore*, [1983] 2 R.C.S. 284 (où la Cour suprême a confirmé que l'infraction d'étiquetage frauduleux des drogues prévue à la LAD relève de la compétence en matière de droit criminel).

740. Voir Robert Emmett CURRAN, *Canada's Food and Drug Laws*, New York, Commerce Clearing House, 1953, pp. 137, 146 (observations relatives à l'*Acte de la falsification des substances alimentaires* de 1884).

741. Voir *Loi modifiant la Loi des aliments et drogues*, S.C. 1939, ch. 3, analysée par R.E. CURRAN, *op. cit.*, note 740, pp. 180, 289. Voir également les art. 16 et 17 de la LAD actuelle, précitée, note 738.

742. R.E. CURRAN, *op. cit.*, note 740, p. 1071.

En pratique, la LAD établit des normes nationales minimales uniformes relativement aux techniques utilisées pour remplacer des tissus humains (recours à d'autres tissus humains, à des tissus synthétiques ou à des organes mécaniques). Les techniques plus anciennes — celles qui concernent les produits sanguins, par exemple — sont régies par des dispositions de la LAD, en vigueur depuis longtemps déjà, qui ont trait à la réglementation des substances biologiques. Le terme « substances biologiques » se rapporte à une catégorie spéciale de produits, notamment les vaccins contre la poliomyélite ou les facteurs de coagulation du sang, obtenus à partir de tissus humains et animaux[743]. Ainsi, le Bureau des produits biologiques de Santé et Bien-être social Canada est chargé de l'application des règlements pris en vertu de la LAD qui portent sur diverses questions liées à l'utilisation des produits sanguins au Canada : consentement et sélection des donneurs, fréquence des dons, traitement, étiquetage et vente, attribution de licences[744]. Depuis des dizaines d'années, du reste, la LAD exige que le placenta utilisé à des fins thérapeutiques soit exempt de toute contamination[745]. Ces dispositions ont contribué à garantir l'innocuité de l'albumine, un dérivé du sang obtenu à partir des placentas et utilisé dans le traitement des chocs, des brûlures et des hémorragies[746]. Par ailleurs, la sécurité et l'efficacité des méthodes offertes par la biotechnologie, grâce auxquelles on fabrique notamment l'hormone de croissance et l'insuline, tiennent en partie au fait qu'elles doivent satisfaire aux normes applicables aux nouveaux médicaments. Les techniques de transplantation d'organes, plus récentes, peuvent quant à elles faire l'objet d'une réglementation indirecte, dans la mesure où les organes en question sont conservés dans des solutions renfermant des substances ou des médicaments visés par les règlements pris en vertu de la LAD.

La LAD impose également, par l'entremise du Bureau des instruments médicaux, des responsabilités en matière de santé et de sécurité en ce qui a trait aux instruments médicaux utilisés pour remplacer certains tissus humains[747]. Le rein et le cœur artificiels

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743. Voir Regulations under the *Food and Drugs Act*, C.P. 1942-9056, Gaz. C., 1942.I.2151, 2172 [ci-après C.P. 9056].

744. Voir SANTÉ ET BIEN-ÊTRE SOCIAL CANADA, *Codification ministérielle de la* Loi des aliments et drogues *et du* Règlement sur les aliments et drogues (et leurs modifications jusqu'au 3 mai 1990), Ottawa, SBEC, 1981 [ci-après règl. LAD], art. C.04.400 et suiv. (règlement relatif au don de sang pour plasmaphérèse). Voir également *Loi des aliments et drogues — Modification* (Annexe n° 671), Gaz. C.1988.I.3360 (3 septembre 1988) (où l'on propose que les règlements concernant les dérivés du sang s'appliquent aussi au sang entier). Voir en général Sanda RODGERS, « The Canadian Blood Delivery System : Liability for Blood Related Injuries » (1989), 21 *Rev. d'Ottawa* 311, 322 ; D.W. BOUCHER et J. FURESZ, « Regulatory Control of Blood Products in Canada » (1987), 67 *Dev. Biol. Stand.* 221.

745. « Un fabricant ne doit se procurer les placentas et les cordons employés à la fabrication de préparations de provenance humaine que de femmes accouchées dans des hôpitaux publics ; les donneuses desdits placentas et cordons doivent avoir été exemptes de toxémies de la grossesse et les placentas et les cordons ne doivent présenter aucun indice macroscopique de quelque état pathologique que ce soit. », règl. LAD, précité, note 744, art. C.04.234. Le règlement remonte au moins au début des années quarante. Voir C.P. 9056, précité, note 743, 2179.

746. P.J. HAGEN, *op. cit.*, note 38, p. 93. L'Institut Mérieux, établissement français qui a récemment acheté Connaught Laboratories de Toronto, est spécialisé dans les dérivés du sang placentaire. De nos jours, au Canada, l'albumine est dérivée du plasma fractionné.

747. Voir LAD, précitée, note 738, art. 19-21. Voir également *Règlement sur les instruments médicaux*, C.R.C., ch. 871 [ci-après désigné « Instruments »].

sont peut-être les exemples les plus familiers[748]. Par exemple, la décision prise récemment par Santé et Bien-être social Canada de continuer à autoriser l'utilisation du cœur artificiel Jarvick-7 de fabrication américaine — après que les autorités américaines en eurent suspendu l'usage en raison de l'insuffisance du contrôle de la qualité — a un effet direct sur la recherche, les pratiques médicales et les patients des hôpitaux canadiens où l'on a recours à l'appareil en question[749]. Le *Règlement sur les instruments* vise aussi les « implants ». On entend par là les instruments destinés à être implantés dans le corps humain pour une période de trente jours ou plus[750] : stimulateurs cardiaques, pompes à infusion, sutures de nylon, implants mammaires en silicone, vaisseaux sanguins synthétiques, etc. Pour être autorisée à vendre des implants au Canada, une société doit normalement démontrer que la fabrication du produit répond à des contrôles adéquats d'efficacité et de qualité, que le produit est efficace, qu'il ne présente aucun risque exagéré lorsqu'il est utilisé de la façon prescrite et qu'il est bien étiqueté[751]. Au cours des dernières années, c'est notamment sur le rôle qui lui est confié à l'égard de la sécurité des implants que Santé et Bien-être social Canada s'est appuyé pour surveiller le rappel par les fabricants de valves cardiaques mécaniques et d'implants de tissu cérébral qui s'étaient avérés défectueux[752].

En ce qui concerne l'application de la LAD aux autres techniques de remplacement de tissus, la situation est moins claire. La moelle osseuse, les tissus, les valves cardiaques humaines ou le sperme (qui peuvent être conservés, congelés, traités) sont-ils visés par les dispositions de la LAD ? Ces substances et tissus sont-ils des « drogues » ou des « instruments médicaux » dans la mesure où ils sont destinés à être utilisés dans le traitement de maladies ou d'affections, ou pour corriger des fonctions corporelles ou organiques[753] ? La réponse semble fonction de l'utilisation du tissu ou de la substance en particulier, et de l'interprétation donnée à la loi.

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748. Voir *supra*, ch. I, section II.C.

749. Voir Christie McLaren, « Canada Allows Jarvik Heart After U.S. Ban », *The [Toronto] Globe and Mail* (12 janvier 1990) A8.

750. Voir *Règlement sur les instruments médicaux — Modification*, DORS 82-914 (modifiant la partie V).

751. Voir Instruments, précité, note 747, art. 33-41.

752. Voir *ibid.*, art. 29. Voir également *infra*, pp. 185-86.

753. Selon l'art. 2 de la LAD, précitée, note 738,

> Sont compris parmi les drogues les substances ou mélanges de substances fabriqués, vendus ou présentés comme pouvant servir :
>
> *a*) au diagnostic, au traitement, à l'atténuation ou à la prévention d'une maladie, d'un désordre, d'un état physique anormal, ou de leurs symptômes, chez l'homme ou les animaux ;
>
> *b*) à la restauration, à la correction ou à la modification des fonctions organiques chez l'homme ou les animaux.

L'art. 2 définit également « instrument » :

> Tout article, instrument, appareil ou dispositif [...] fabriqué ou vendu pour servir, ou présenté comme pouvant servir :
>
> *a*) au diagnostic, au traitement, à l'atténuation ou à la prévention d'une maladie, d'un désordre, d'un état physique anormal [...]
>
> *b*) à la restauration, à la correction ou à la modification d'une fonction organique ou de la structure corporelle de l'homme [...].

D'une part, on pourrait faire valoir que la rédaction, la structure et l'esprit de la loi indiquent que le champ d'application de celle-ci embrasse ces tissus et substances. Tous servent à traiter des maladies ou des dysfonctionnements touchant des tissus humains ; la loi n'exige pas une utilisation curative. Certains de ces tissus, notamment les produits sanguins et le sperme, font l'objet de ventes au sens normal du terme. Par ailleurs, presque tous sont vendus, si l'on se fonde sur la définition de la « vente » figurant dans la LAD, qui assimile à la vente le fait d'avoir la chose en sa possession pour la vente ou de la distribuer, pour une contrepartie ou non[754]. On utilise couramment, avec efficacité et sans risques, de plus en plus de types de tissus humains dans le traitement des troubles corporels, grâce à des techniques complexes de conservation, de traitement et de préparation qui, au bout de multiples opérations, permettent d'obtenir des agents thérapeutiques « fabriqués » assez semblables aux agents thérapeutiques produits selon les méthodes traditionnelles. Exemple classique : les facteurs de coagulation fabriqués par l'industrie internationale de plasmaphérèse ; autre exemple, moins connu celui-là : les lentilles cornéennes vivantes, produites à partir d'yeux humains prélevés, traités et stockés, et adaptées au patient avant l'implantation[755]. De ce point de vue, donc, le grand objectif de la Loi — protéger la santé publique — et le caractère des définitions y figurant (elles ne prétendent aucunement à l'exhaustivité) indiqueraient que le Parlement entendait donner à ce texte un champ d'application très large et souhaitait voir ses définitions interprétées en ce sens[756].

D'autre part, on pourrait estimer au contraire que la LAD a une portée plus restreinte. À l'appui de cette thèse, on dira que les tissus ne peuvent être assimilés aux agents thérapeutiques traditionnels, qui ont un effet direct sur la physiologie humaine et sont généralement reconnus par l'industrie pharmaceutique et le public comme des médicaments ou des instruments médicaux au sens traditionnel de ces termes. En outre, certains tissus sont traités mais seul un petit nombre sont « fabriqués », au sens commercial normalement attribué à ce terme[757]. Une controverse a opposé certains tribunaux américains, au cours des années soixante, sur la question de savoir si certains tissus étaient visés par des dispositions presque identiques à celles que l'on trouve dans la LAD[758]. On trouvera au tableau 2, ci-dessous, une liste de techniques régies (ou vraisemblablement régies) par la LAD.

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754. Voir *ibid.*, définition du mot « vente ».

755. Voir Jonathan M. FRANTZ, Marguerite B. MCDONALD et Herbert E. KAUFMAN, « Results of Penetrating Keratoplasty after Epikeratophakia for Keratoconus in the Nationwide Study » (1989), 96:8 *Ophthalmology* 1151.

756. Cette interprétation a été retenue dans *United States* c. *Bacto-Unidisk*, 394 U.S. 784 (1969) (le tribunal a conclu qu'un disque d'antibiogramme était soumis à la réglementation fédérale sur les aliments et les médicaments).

757. La loi ne contient aucune définition du terme « fabriquer », mais dans les *Bonnes pratiques de fabrication* établies en vertu de la loi, le terme « produire » est défini de la façon suivante : « fabriquer, préparer, conserver, emballer, étiqueter, analyser ou entreposer une drogue en vue de la vendre ». Voir règl. LAD, précité, note 744, art. C.02002.

758. Comparer *United States* c. *Calise*, 217 F. Supp. 705 (1962) (le sang entier est un médicament) ; *United States* c. *Steinschreiber*, 219 F. Supp. 373, 383 (1963) (le plasma sanguin humain est un médicament), confirmé par 326 F. 2d 759 (2d Cir.) ; *Blank* c. *United States*, 400 F. 2d 302, 303-304 (5th Cir. 1968) (le sang entier citraté et les concentrés de globules rouges ne sont pas des médicaments). À la suite de l'affaire *Blank*, la loi américaine sur les médicaments a été modifiée. Voir Pub. L. nº 91-515, 84 Stat. 1297, 1308 (1970).

TABLEAU 2

Santé et Bien-être social canada :
Responsabilité quant à la sécurité des techniques de remplacement des tissus

Contrôles avant et après la mise sur le marché des médicaments et des instruments médicaux

licences : délivrance, suspension, révocation
- normes de sécurité et d'efficacité
- saisie des marchandises falsifiées
- restrictions publicitaires
- essais avant la mise en marché
- poursuites
- inspections
- étiquetage
- rappels

Bureau des produits biologiques	**Bureau des instruments médicaux**
Vaccins	Cœur artificiel, rein artificiel
Produits sanguins	Implants
sang entier	valves cardiaques mécaniques
plasma humain	articulations artificielles
albumine	stimulateurs cardiaques
facteurs de coagulation	lentilles intraoculaires
Médicaments dérivés de l'ADNr	sutures de nylon
hormone de croissance	implants mammaires en silicone
insuline	vaisseaux sanguins
EPO, facteur VIII	synthétiques
	pompes à insuline implantables

Produits biologiques ? Instruments ? Implants ?

bioprothèses cardiaques traitées, conservés, implantées
- veines ombilicales bioprosthétiques traitées, implantées
- lentilles oculaires traitées, cryogénées, implantées
- moelle osseuse traitée, conservée
- sperme traité, conservé
- dure-mère traitée

Les progrès de la biotechnologie réalisés au cours des dernières décennies ont accru et accéléré la tendance à utiliser des tissus synthétiques et biosynthétiques plutôt que des tissus naturels, dans le cadre des techniques de remplacement. La transformation et le stockage de tissus humains thérapeutiques devenant de plus en plus courants, la question de savoir si la LAD s'applique à tel ou tel produit tissulaire se posera sans doute avec plus d'acuité, et la nécessité d'établir des normes minimales uniformes et d'application nationale deviendra plus évidente. Si le champ d'application de la LAD s'étend aux valves cardiaques[759], à la moelle osseuse et au sperme[760] traités et stockés, ainsi qu'aux tissus oculaires cryogénés, cela signifie que les citoyens de toutes les régions géographiques du Canada sont protégés par les mêmes normes minimales de sécurité[761]. Dans le cas contraire, l'existence de normes nationales dépend de l'uniformité des lois provinciales pertinentes et des normes et pratiques de la profession médicale. La fréquence et l'importance des échanges interprovinciaux et internationaux de tissus destinés à être utilisés comme agents thérapeutiques implantables justifie-t-elle moins, du point de vue de la santé publique et dans une perspective historique, la protection du public consommateur, que l'utilisation des cosmétiques, régis par la loi depuis une cinquantaine d'années ? Ces considérations sembleraient plaider en faveur de la réglementation des tissus thérapeutiques et des substances préservés ou traités qui ne sont peut-être pas à proprement parler régis par la LAD. Si, pour conclure que la LAD s'applique à ces tissus, il faut exagérément forcer ses définitions, sa fonction et l'objectif poursuivi par le législateur, mieux vaudrait peut-être, pour veiller le mieux possible à la santé et à la sécurité des Canadiens, clarifier les choses par l'adoption de nouvelles dispositions législatives.

(2) Textes sur l'importation et l'exportation

En principe, la LAD exige que les produits importés servant au remplacement de tissus humains répondent aux mêmes normes de sécurité et d'efficacité que les produits canadiens[762]. Ici encore, les produits qui ne sont pas expressément visés par la LAD — par exemple les valves cardiaques humaines actuellement importées, traitées et stockées[763] — échappent vraisemblablement à ces normes et à ces garanties. L'exemption générale établie dans la LAD au sujet des exportations, dont il est question plus loin dans ce document, soulève des questions fondamentales ressortissant aux obligations du Canada envers les États importateurs et les consommateurs étrangers[764].

Aux contrôles prévus par la LAD viennent s'ajouter ceux établis dans la *Loi sur la quarantaine* et le *Tarif des douanes*. Fondée sur la compétence législative du Parlement

759. Voir le texte accompagnant la note 1027, *infra*.

760. *Ibid.*

761. L'article 30 de la LAD, précitée, note 738, confère au gouverneur en conseil le pouvoir de prendre des règlements concernant l'importation des drogues (par. 30(2)) et des instruments médicaux (al. 30(1)*d*)).

762. *Id.*, al. 30(1)*d*) ; Instruments, précité, note 747, art. 14, 16-22 ; Règl. LAD, précité, note 744, art. G.002.008.

763. Voir le texte accompagnant la note 1027, *infra*.

764. Voir, *infra*, la discussion concernant le commerce international, ch. IV.

du Canada en la matière[765], la *Loi sur la quarantaine* confère à Santé et Bien-être social Canada le droit d'inspecter et de retenir les marchandises importées susceptibles de menacer la santé publique[766]. Ainsi, les règlements pris en vertu de la *Loi sur la quarantaine* prévoient actuellement que les éléments du corps humain importés ne peuvent entrer au Canada que s'ils sont accompagnées d'un certificat médical indiquant qu'ils ne présentent aucune infection[767]. Les règlements sur les douanes favorisent par ailleurs l'entrée rapide d'organes humains au Canada[768]. Les règlements adoptés en vertu du *Tarif des douanes*[769] imposent des droits de douane sur les marchandises importées et établissent les dispositions tarifaires applicables aux partenaires commerciaux du Canada. En vertu des annexes, par exemple, le plasma sanguin, les os, les organes et d'autres tissus humains destinés à la transplantation entrent au Canada en franchise, mais les hormones extraites des glandes humaines sont assujetties à des droits de douane[770]. De la même manière, les règlements sur l'immigration prévoient que les équipes médicales accompagnant les corps de personnes en état de mort cérébrale maintenues en vie par des moyens mécaniques, ainsi que les équipes de prélèvement d'organes, peuvent passer rapidement aux douanes[771].

(3) *Loi sur les brevets*

La loi fédérale sur les brevets vise à encourager l'ingéniosité, en accordant en principe aux inventeurs le droit exclusif, pendant vingt ans, de fabriquer, d'utiliser ou de vendre leur invention au Canada[772]. En théorie, ce droit exclusif a pour effet de stimuler la recherche sur des inventions pouvant exiger des années de labeur intellectuel et de nombreux investissements financiers. La loi sur les brevets peut également contribuer à la mise au point d'autres inventions, les titulaires de brevets étant tenus de divulguer les renseignements techniques sur lesquels leur invention est fondée[773].

Les inventeurs des valves cardiaques mécaniques, des nouvelles solutions de conservation prolongée des organes[774], des hormones de croissance humaine (HCH) dérivées de l'ADN recombinant ayant remplacé l'HCH prélevée sur les glandes pituitaires des cadavres, se sont prévalus de ces mesures d'incitation et de ces protections pour la mise en marché de ces techniques de remplacement de tissus humains. Des brevets ont

765. Voir *Loi constitutionnelle de 1867*, précitée, note 506, par. 91(11).

766. Voir L.R.C. (1985), ch. Q-1, art. 5.

767. Voir Revenu Canada, Douanes et Accise, Memorandum D19-9-3, « Dépouilles mortelles et parties du corps humain devant être enterrées au Canada » (1er juin 1986).

768. Revenu Canada, Douanes et Accise, Memorandum R19-9-4, « Expédition d'organes humaines » (1er juin 1986).

769. L.R.C. (1985), ch. 41 (3e suppl.).

770. Voir Numéros tarifaires 3001.90.20, 3001.90.90 de la *Loi de mise en œuvre de l'Accord de libre-échange Canada — États-Unis*, S.C. 1988, ch. 65, art. 106 (partie B de l'Annexe).

771. Voir *Règlement sur l'immigration de 1978*, al. 19(1)*j*), mod. par, DORS/84-849, Ann., par. (1).

772. *Loi sur les brevets*, L.R.C. (1985), ch. P-4, modifiée par L.R.C. 1985, ch. 33 (3e suppl.), art. 2, 44, 46.

773. Voir *Pioneer Hi-Bred*, *infra*, note 777.

774. Voir *supra*, note 137.

également été délivrés aux États-Unis et le seront vraisemblablement au Canada, en ce qui a trait au sang synthétique et à des hormones fabriquées génétiquement qui favorisent la croissance des cartilages et des os[775]. On constate donc que le régime en vigueur en matière de brevets a contribué à la santé publique.

Des difficultés se posent néanmoins. Au moment où Santé et Bien-être social Canada se préparait à délivrer une licence à l'égard de l'érythropoïétine — cette substance, fabriquée grâce au génie génétique, qui stimule la production de globules rouges et aide à diminuer le nombre de transfusions sanguines nécessaires dans le cas des patients en dialyse et des patients ayant reçu une transplantation rénale —, des sociétés américaines de biotechnologie se disputaient devant les tribunaux les droits d'exploitation des brevets relatifs à l'EPO, dont les ventes annuelles atteignent les 300 millions de dollars[776]. Si de tels différends sont monnaie courante en matière de brevets, la biotechnologie suscite de nouvelles questions. Par exemple, le fait de breveter la vie[777], particulièrement les formes de vie humaine, ne pourrait-il, jusqu'à un certain point, être jugé répréhensible en soi ? Comme les lignées cellulaires peuvent officiellement être brevetées au Canada depuis le début des années quatre-vingt, on est porté à répondre par la négative[778]. Quoi qu'il en soit, l'affaire *Moore*[779] montre qu'il est indispensable de se pencher sur les conséquences qu'entraîne la possibilité de délivrer des brevets à l'égard de certaines formes de vie humaine. Comment peut-on protéger l'intégrité corporelle et la dignité des patients dont proviennent les tissus en cause, tout en offrant les encouragements et la protection nécessaires aux biotechnologues qui, dans un but lucratif, tentent de mettre au point des substances thérapeutiques dont les travaux sont susceptibles de profiter au public ?

(4) *Loi sur la santé*

Le législateur a jugé que l'accès à des soins de santé de qualité était « déterminant » pour la conservation et l'amélioration de la santé et du bien-être de tous les Canadiens[780].

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775. Voir Edmund L. ANDREWS, « Patents : Synthetic Blood », *New York Times* (21 octobre 1989) ; Edmund L. ANDREWS, « Patents : Gains on Interleukin 3 and Formation of Bone », *New York Times* (4 novembre 1989) 34.

776. *Amgen Inc.* c. *Chugai Pharmaceutical Co.*, 927 F. 2d 1200 (Fed. 1991), cert. refusé. Voir également OTA, *Recombinant Erythropoietin: Payment Options for Medicare*, Washington (D.C.), U.S. Government Printing Office, 1990. Pour des précisions médicales sur l'EPO, voir *supra*, ch. I, section II.C(3).

777. Les formes de vie microbienne simples semblent être brevetables en Amérique du Nord. Comparer *Pioneer Hi-Bred* c. *Canada (Commissaire des brevets)*, [1989] 1 R.C.S. 1623, 1643 et *Diamond* c. *Chakrabarty*, 477 U.S. 303 (1980). Voir en général OTA, *New Developments in Biotechnology: Patenting Life*, Washington (D.C.), U.S. Government Printing Office, 1989 ; Rachel E. FISHMAN, « Patenting Human Beings: Do Sub-Human Creatures Deserve Constitutional Protection? » (1989), 15 *Am. J.L. Med.* 461 ; Michèle RIVET, « Patenting Life-Forms and Owning Human Tissue », allocution devant l'Institut canadien d'administration de la justice, Vancouver, août 1990.

778. Comparer *Application of Abitibi Co.* (1982), 62 C.P.R. (2e) 81, 89 (Pat App. Bd. et Commissaire des brevets), *Pioneer Hi-Bred*, précité, note 777 et brevet n° 999, 546 du 9 novembre 1976 (« human liver cell live »). Voir également BUREAU DES BREVETS, *Recueil des pratiques du Bureau des Brevets*, Ottawa, Consommation et Corporations Canada, 1979, art. 12.03.02 (révision 1/90) (« les inventions portant sur de nouvelles formes de vie microbienne, telles les bactéries, levures [. . .] souches de cellules [. . .] peuvent être brevetés. »).

779. Voir *Moore* (1990), précité, note 426.

780. Voir le préambule de la *Loi sur la santé*, L.R.C. (1985), ch. C-6.

Il a donc proclamé que l'« accès satisfaisant » aux services de santé, « sans obstacles d'ordre financier ou autre » constituait le premier objectif de la politique canadienne de la santé[781]. Or dans le contexte des greffes et transplantations de tissus humains, il semble y avoir deux cas où des obstacles financiers ou autres peuvent empêcher l'accès aux services de santé.

Premièrement, la pénurie de tissus humains peut constituer un obstacle non financier[782]. Pour les patients inscrits sur les listes d'attente au Canada, le manque d'organes représente bien sûr une terrible menace. Cependant, si la demande nationale à l'égard des produits sanguins, des tissus cornéens ou des reins est régulièrement supérieure à l'offre, au point où la pénurie devient constante et grave, c'est à la fois la vie d'individus et la réalisation des objectifs nationaux qui sont mis en péril. Cette pénurie peut ainsi constituer un obstacle important à la conservation de la santé. Selon certains spécialistes, le problème ne revêt pas encore une dimension nationale au Canada, mais il n'en reste pas moins que dans une situation analogue, quelques États ont décider de procéder à des réformes législatives[783]. De telles réformes, lorsqu'elles contrecarrent efficacement la pénurie, peuvent sauver des vies et favoriser la politique nationale de la santé.

Deuxièmement, l'insuffisance de crédits peut également poser des obstacles à l'accès. Dans la *Loi sur la santé* nationale ainsi que dans les régimes provinciaux d'assurance maladie adoptés en conformité avec elle, l'État s'est engagé à réduire le plus possible les obstacles financiers grâce à l'adoption d'un régime universel d'assurance maladie. La loi fédérale oblige expressément les provinces à fournir de façon uniforme un « accès satisfaisant » aux hôpitaux et aux services de santé « médicalement nécessaires »[784]. Toutefois, l'accès satisfaisant n'est pas synonyme d'accès absolu. Du reste, des litiges récents au sujet du financement des transplantations aux États-Unis portent à croire que le terme « médicalement nécessaire » prête à interprétation[785]. Il n'en demeure pas moins que la province qui déciderait, par exemple, de ne plus financer les transplantations rénales, et se trouverait ainsi à entraver ou à interdire l'accès « satisfaisant » à des transplantations jugées médicalement nécessaires, s'exposerait à se voir priver de crédits fédéraux[786].

Il n'est pas étonnant, à la lumière de ces préoccupations touchant la pénurie et les coûts, que les comités fédéro-provinciaux chargés d'étudier l'application de la *Loi sur*

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781. *Id.*, art. 3.

782. Voir *supra*, ch. I, particulièrement le Tableau 1, à la p. 11, et section V.

783. Voir, par exemple, les États-Unis et l'Australie, *infra*, ch. IV.

784. Voir *Loi sur la santé*, précitée, note 780, art. 12, 2 (la loi énonce que tout régime provincial d'assurance maladie « offre les services de santé assurés selon des modalités uniformes et ne [fait] pas obstacle [. . .] à un accès satisfaisant [. . .] à ces services ». Le terme « services de santé assurés » s'entend des services hospitaliers et le terme « services hospitaliers », « des services fournis dans un hôpital [. . .] si ces services sont médicalement nécessaires pour le maintien de la santé, la prévention des maladies ou le diagnostic ou le traitement des blessures, maladies ou invalidités [. . .] ». On trouvera des observations sur l'attribution de ressources insuffisantes, dans ce contexte, *supra*, ch. I, section IV.C.

785. Voir les causes citées à la note 1001, *infra*.

786. Voir *Loi sur la santé*, précitée, note 780, art. 14-17.

la santé se soient intéressés au cours des dernières années aux questions suivantes : données concernant le coût des transplantations, établissement d'une liste d'attente nationale pour les transplantations, offre et demande canadiennes en matière de techniques de remplacement de tissus et d'organes[787].

(5) Textes sur les services de santé

Le gouvernement du Canada a certaines responsabilités à l'égard des soins médicaux fournis aux personnes non couvertes par les régimes provinciaux d'assurance maladie[788] et à certains groupes particuliers au sein de la société canadienne. On peut citer le personnel militaire en service actif, les personnes appartenant à la Gendarmerie royale du Canada[789], les prisonniers détenus dans des établissements fédéraux[790], les anciens combattants[791], les autochtones[792]. Certaines de ces responsabilités sont expressément énoncées dans les lois fédérales.

La *Loi sur les pénitenciers*[793] et le *Code criminel*[794], par exemple, exigent que Service correctionnel Canada offre les soins médicaux nécessaires ou essentiels aux quelque 10 000 détenus dont il a la charge. Cette obligation législative, sans doute renforcée par des obligations tenant aux droits fondamentaux de la personne[795], s'étend aux techniques de

787. Voir FEDS, *op. cit.*, note 29. Voir également SBSC, *Loi canadienne sur la santé, rapport annuel*, Ottawa, SBSC (pour les années 1984 à 1989).

788. La *Loi canadienne sur la santé* exclut spécifiquement de la responsabilité des provinces, les membres des Forces armées canadiennes, de la Gendarmerie royale du Canada, les prisonniers détenus dans des établissements fédéraux et les individus n'ayant pas résidé suffisamment longtemps dans une province pour être admissibles à l'assurance maladie. Voir la définition d'« assuré » dans la *Loi sur la santé*, précitée, note 780, art. 2.

789. *Ibid.*

790. *Ibid.*

791. Voir le *Règlement sur le traitement des anciens combattants*, C.R.C., ch. 1585 et le *Règlement sur les soins de santé pour anciens combattants*, DORS 90-594, pris en vertu de la *Loi sur le ministère des Anciens combattants*, L.R.C. (1985), ch. V-1, par. 5(1).

792. Un traité datant de 1876, par exemple, oblige le gouvernement du Canada à offrir des services médicaux aux autochtones sur les réserves dans certaines parties de l'Ouest canadien. Voir *Traité n° 6 entre Sa Majesté la Reine et les Cris de la Plaine et des Bois et d'autres tribus indiennes*, étudié dans *R.* c. *Swimmer* (1970), 17 D.L.R. (3e) 476 (C.A. Sask.). Le *Règlement sur la santé des Indiens* (C.R.C., ch. 955) a été adopté en vertu de la *Loi sur les Indiens*, L.R.C. (1985), ch. I-5, al. 73(1)g), conformément à la compétence législative fédérale stipulée au par. 91(24) de la *Loi constitutionnelle de 1867*, précitée, note 506. Voir également *Loi sur le ministère de la Santé nationale et du Bien-être social*, L.R.C. (1985), ch. N-10 (responsabilités du gouvernement fédéral en matière de santé). La tendance est au transfert de la responsabilité en matière de santé et d'hôpitaux aux peuples autochtones, mais Santé et Bien-être social administre encore sept hôpitaux autochtones, dont le seul centre de soins intensifs du Yukon, l'hôpital général de Whitehorse.

793. L.R.C. (1985), ch. P-5, art. 37. L'article 16 du *Règlement sur le service des pénitenciers*, C.R.C., ch. 1251, dispose : « Tout détenu doit bénéficier, conformément aux directives, des soins médicaux et dentaires essentiels dont il a besoin ».

794. Alinéa 215(1)c). Voir également *Attorney General of British Columbia* c. *Astaforoff* (1983), 6 C.C.C. (3e) 498 (C.A.).

795. Voir *infra*, section IV.B.

remplacement de tissus humains nécessaires du point de vue médical, notamment la dialyse, les transfusions sanguines, les transplantations de moelle osseuse, etc.[796]. De la même manière, le ministère de la Défense nationale, en raison de la responsabilité qui lui incombe à l'égard des quelque 100 000 Canadiens dans les Forces, a supervisé deux douzaines environ de transplantations de tissus ou d'organes pratiquées sur son personnel au cours des dernières années[797]. Lorsque le recours à de telles techniques est souhaitable du point de vue médical, mais impossible dans les centres de santé relevant de l'administration fédérale, on procède habituellement par ententes contractuelles ou demandes de consultation auprès d'autres hôpitaux. C'est ainsi que les militaires ayant besoin d'une transplantation cardiaque sont parfois dirigés du Centre médical de la Défense nationale à l'Institut de cardiologie d'Ottawa.

(6) *Loi de l'impôt sur le revenu*

La *Loi de l'impôt sur le revenu* a une incidence sur les greffes et transplantations de tissus humains parce qu'elle est susceptible d'offrir des encouragements fiscaux aux donneurs potentiels :

> [TRADUCTION]
> Le paiement offert par l'État pourrait prendre la forme, non pas d'un versement d'argent liquide ou de crédits, mais d'une disposition portant que les offres confirmées de don posthume sont considérées par le fisc comme des dons de charité. Le contribuable qui présenterait une carte de donneur dûment remplie pourrait se voir remettre un reçu qui, joint à la déclaration d'impôt sur le revenu de l'année suivante, lui donnerait le droit de déduire une certaine somme de son revenu[798].

Il est difficile de savoir, au regard des dispositions actuelles de la *Loi de l'impôt sur le revenu*, si le don d'un organe ou d'un tissu peut satisfaire aux exigences ayant trait aux dons de charité ou aux déductions[799]. Aux États-Unis, la question a été abordée par le législateur[800]. Si les encouragements fiscaux sont susceptibles d'améliorer la situation dans le cas de tissus et d'organes dont l'« offre » est insuffisante, les avantages économiques d'une telle politique risquent toutefois de profiter surtout aux contribuables à revenus

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796. Voir SERVICE CORRECTIONNEL CANADA, « Directive du commissaire 800 : Services médicaux, dentaires et de santé » (1er janvier 1987, par. 26) (chirurgie majeure) ; SERVICE CORRECTIONNEL CANADA, « Directive du commissaire 830 : Prothèses et appareils médicaux » (1er janvier 1987), par. 1 (« Veiller à ce que l'on fournisse aux délinquants les prothèses et appareils médicaux nécessaires pour corriger des déficiences d'ordre physique. »).

797. Les transplantations suivantes ont été pratiquées sur des membres du personnel de la Défense nationale, de 1984 à 1988 : moelle osseuse (9), cornée (7), reins (2), cœur/poumon (1), cœur (2), en plus d'une dialyse. Source : Ministère de la Défense nationale, Bureau du directeur général des services de santé, 1990.

798. B.M. DICKENS, *loc. cit.*, note 459, 21.

799. Voir *Loi de l'impôt sur le revenu*, S.R.C. 1952, ch. 148; S.C. 1970-71-72, ch. 63, al. 118.1(1)*a*), ajouté par S.C. 1988, ch. 55, par. 77(1), 92(1) (remplacement de la déduction pour dons de charité par un crédit). Comparer *Garber*, précité, note 434.

800. Voir H.R. 540, 98th Cong., 1st Sess. (1983). Voir en général Note, « Tax Consequences of Transfers of Bodily Parts » (1973), 73 *Colum. L. Rev.* 842.

élevés. En outre, elle pourrait battre en brèche les sentiments profonds des citoyens à l'égard de la notion d'altruisme[801].

B. Lois provinciales relatives aux prélèvements et aux greffes

Tandis que le droit fédéral, dans le domaine qui nous occupe, s'intéresse en général aux questions liées à la sécurité et au commerce, les lois provinciales établissent les mécanismes régissant les dons, les greffes et les transplantations de tissus, d'organes et d'éléments du corps humain. Elles sont le résultat de trois vagues législatives dont la première remonte au milieu du XIX[e] siècle.

(1) Lois sur l'anatomie

Le mouvement a en effet été déclenché en 1849, par l'adoption d'une loi au moyen de laquelle on voulait que les facultés de médecine puissent obtenir des cadavres à des fins de dissection et de formation médicale. Lorsque le Conseil médical de Montréal déposa une requête à l'Assemblée Législative de la Province du Canada en 1843, il cherchait une solution législative à un problème médical et social dont on trouve un résumé dans le préambule de la loi :

> Attendu qu'il est impossible d'acquérir une connaissance suffisante de la Chirurgie ou de la Médecine, sans avoir une connaissance exacte et pratique de la structure et des fonctions respectives de toutes les parties de l'économie animale de l'homme, qui ne peut s'acquérir que par des cours de dissection longtemps et diligemment suivis : Et attendu qu'il est maintenant très difficile sinon impossible d'acquérir ces connaissances, et que vu l'importance progressive des Écoles de Médecine de cette Province, et pour le soulagement de l'humanité souffrante, il est devenu nécessaire de faire des dispositions législatives en vertu desquelles les Professeurs d'Anatomie ou de Chirurgie à ce dûment autorisés pourront être pourvus des sujets qui leur seront nécessaires pour instruire les étudiants confiés à leurs soins [...][802].

Suivant les partisans de ce texte législatif, la pratique de l'anatomie était « légalement impossible »[803]. Pour recevoir leur licence, les étudiants en médecine devaient avoir pratiqué une « chirurgie sur un cadavre ». Or, les cadavres se faisaient rares, ce qui incitait les étudiants à en dérober dans les cimetières locaux, s'exposant ainsi à des accusations criminelles (profanation de restes humains)[804]. Les opposants, pour leur part, prétendaient que l'adoption de cette loi légaliserait le trafic des cadavres, qu'elle ferait de certains défunts des biens publics, et des criminels exécutés une source d'approvisionnement privilégiée[805].

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801. Voir B.M. DICKENS, *loc. cit.*, note 459, 21.

802. *Loi sur l'anatomie*, précitée, note 8 (préambule).

803. Voir *Debates of the Legislative Assembly of United Canada 1841-1867 : Volume III*, Montréal, Presses de l'École des hautes études commerciales, 1972, p. 464 [ci-après Débats]. Voir également *Journaux de l'Assemblée Législative de la Province du Canada*, Session du 28 septembre au 9 décembre 1843, p. 200.

804. Voir D.G. LAWRENCE, *loc. cit.*, note 4, 409. Voir également *Lynn*, précité, note 680 (le vol de tombeaux est une infraction criminelle en common law).

805. Voir Débats, *op. cit.*, note 803, pp. 464-466.

Le législateur a fini par conclure que l'adoption du texte allait aider la médecine à sauver des vies et permettre de venir à bout du viol des sépultures ainsi que du marché noir qui en découlait. La loi reconnaissait le principe selon lequel les cadavres non réclamés exposés publiquement ou se trouvant dans des établissements publics — hôpitaux, prisons, etc. — devaient être mis à la disposition des facultés de médecine[806]. Ce principe découlait directement d'une pratique élaborée à Paris[807] au XIX^e siècle, et dont l'idée avait du reste été reprise une dizaine d'années plus tôt dans des lois sur l'anatomie adoptées en Grande-Bretagne et au Massachusetts[808].

À en juger par le nombre de vols de cadavres commis après 1843, les effets des dispositions adoptées par le législateur canadien semblent avoir tardé à se faire sentir. Bien plus tard, dans les années 1870, un démonstrateur d'anatomie à la Faculté de médecine de l'Université McGill sera par exemple condamné à une amende pour avoir obtenu des cadavres sur le marché noir :

> [TRADUCTION]
> À l'occasion, ils m'accusaient d'avoir reçu des cadavres. Mais comme il n'y a aucun droit de propriété sur un cadavre et qu'aucun vêtement n'avait été pris, le seul chef d'accusation possible était celui d'« infraction contre la décence », et j'étais habituellement condamné à une amende de 50 $. Le juge, un certain M. Coursol, convenait de la nécessité d'obtenir du matériel pour la dissection ; il me condamnait à l'amende, sans rien dire de plus[809].

Peut-être de telles poursuites étaient-elles chose rare, mais ce n'était apparemment pas le cas de la pratique elle-même. On rapporte que des cadavres étaient même obtenus en fraude aux États-Unis[810]. L'augmentation du nombre de facultés de médecine et d'étudiants entraînait un accroissement de la demande. Au Québec, les municipalités prenaient des moyens extraordinaires afin de protéger les cimetières locaux contre les vols

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806. « Qu'il soit en conséquence statué [...] que les cadavres des personnes trouvées mortes, et exposées publiquement, ou de celles qui immédiatement avant leur décès auront été dans et à la charge de quelque Institution Publique recevant quelques secours pécuniaires du Gouvernement Provincial, seront délivrés aux personnes désignées comme ci-dessous mentionné, à moins que la personne ainsi décédée ne l'ait autrement voulu : Pourvu toujours, que si tels cadavres sont réclamés dans le temps ordinaire de l'inhumation, par des amis ou parents, *de bonne foi*, ou si les personnes ont déclaré leur volonté à cet égard comme susdit, les cadavres seront livrés à leurs parents ou amis, ou décemment inhumés. » *Loi sur l'anatomie*, précitée, note 8 (préambule).

807. Voir Débats, *op. cit.*, note 803, p. 466. Voir également *Select Committee on Anatomy*, *op. cit.*, note 22, pp. 9-10, 137.

808. *Anatomy Act, 1832* (R.-U.), 2 & 3 Will. IV, ch. 95 ; *An Act more effectively to Protect the Sepulchres of the Dead and to Legalize the Study of Anatomy in Certain Cases*, 1831 Laws of the commonwealth of Massachusetts, ch. 57. Voir également *Report of the Select Committee of the House of Representatives, on Legalizing the Study of Anatomy*, Boston, Dutton and Wentworth, 1831.

809. Francis J. SHEPHERD, *Reminiscences of Student Days and Dissecting Room*, Montréal, 1919, p. 25. Voir également Edward Dagge WORTHINGTON, *Reminiscences of Student Life and Practice*, Sherbrooke (Qc), Walton, 1897.

810. Voir D.G. LAWRENCE, *loc. cit.*, note 4, 414.

de cadavres[811]. Plusieurs facteurs semblent avoir affaibli la portée des dispositions législatives adoptées : la loi n'a pas été appliquée, les hôpitaux n'ont pas voulu s'y conformer, la loi était ambiguë quant au délai devant s'écouler avant qu'un cadavre soit déclaré « non réclamé », il n'était pas expressément interdit aux facultés de médecine de recevoir des cadavres provenant du « marché noir »[812].

De nos jours, les lois provinciales sur l'anatomie — ou leurs équivalents — permettent aux facultés de médecine d'obtenir quelque six cents cadavres par an aux fins d'enseignement et de recherche[813]. Les modifications apportées depuis le XIX^e siècle ont permis de dissiper les ambiguïtés et de remédier aux lacunes du texte initial. La plupart des lois fixent ainsi une période d'attente de vingt-quatre à quarante-huit heures à l'issue de laquelle le cadavre est réputé non réclamé[814]. L'introduction du principe du legs dans les textes régissant le don de tissus permet à chacun de donner son corps à la science médicale[815]. C'est du reste par ce truchement que les facultés de médecine se procurent la très grande majorité des cadavres qu'elles utilisent.

(2) Lois sur les greffes de la cornée

Un siècle après l'adoption au Canada, en Grande-Bretagne et aux États-Unis de lois visant à répondre aux besoins des facultés de médecine en matière d'anatomie, on allait assister à une deuxième vague de textes législatifs. Dans les années cinquante, la science médicale a commencé à traiter certaines formes de cécité et de troubles graves de la vue par la transplantation chirurgicale de tissus oculaires prélevés sur des cadavres[816]. Comme les dispositions des lois sur l'anatomie qui établissaient la possibilité de faire don de son corps à la science ne prévoyaient ni n'autorisaient le prélèvement de tissus aux fins de transplantation, une réforme législative s'imposait[817]. C'est ce qui a amené le législateur britannique à adopter le *Corneal Grafting Act*, en 1952, pour autoriser le prélèvement de cornées sur les cadavres, à des fins thérapeutiques[818]. Cinq ans plus tard, le Nouveau-

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811. L'avis suivant a paru dans un journal montréalais en 1871 :

> [TRADUCTION]
> Nous avons vu aujourd'hui l'arme formidable qui vient d'être fabriquée pour le gardien du cimetière de la Côte-des-Neiges. Le fusil est énorme et il sera chargé de huit onces de chevrotine. Ceux qui pensent faire une rafle dans le cimetière feront bien de se rappeler l'arme formidable qui se trouve désormais entre les mains du gardien, lequel aura les yeux bien ouverts. Un coup tiré en direction d'une bande de profanateurs fournirait vraisemblablement à la salle de dissection des sujets pour plusieurs semaines.

Voir D.G. LAWRENCE, *loc. cit.*, note 4, 415, où l'on cite le *Montreal Evening Star*, 11 février 1871.

812. Voir D.G. LAWRENCE, *loc. cit.*, note 4.

813. Voir *supra*, ch. I.

814. Voir, par exemple, *Anatomy Act*, R.S.O. 1980, ch. 21, art. 3 et *Loi sur la protection de la santé publique*, L.R.Q., ch. P-35, art. 57.

815. Voir, par exemple, la loi uniforme de 1971, art. 4, dont il est question *infra*, à la section III.B(3).

816. Voir *supra*, ch. I, section I.B(1).

817. Voir W.A.J. FARNSDALE, *Law on Human Transplants and Bequests of Bodies*, Beckerman, Ravenswood, 1970, p. 16.

818. 15 & 16 Geo. VI & 1 Eliz. II, ch. 28.

Brunswick adoptait une loi s'inspirant largement du modèle britannique[819]. La Conférence des Commissaires pour l'uniformité de la législation au Canada proposait, par la suite, le *Uniform Cornea Transplant Act*[820], dont le texte fut ultérieurement adopté par huit provinces et deux territoires[821].

Le *Uniform Cornea Transplant Act* s'inspirait et s'écartait tout à la fois du principe des cadavres non réclamés. Le principe du don était instauré, chacun se voyant autorisé à indiquer de son vivant son intention de faire don de ses yeux après sa mort[822]. On en étendait l'application aux cas où la personne n'a pas exprimé son intention à cet égard, en énonçant que le conjoint du défunt, ses enfants, ses parents ou ses frères et sœurs pouvaient autoriser le prélèvement[823]. Lorsque les membres de la famille ne pouvaient être retrouvés, une personne étant [TRADUCTION] « légalement en possession du corps » pouvait donner cette autorisation — règle inspirée du principe relatif à l'utilisation par les facultés de médecine de cadavres non réclamés[824].

Il était précisé dans la loi que l'expression « légalement en possession du corps » ne pouvait s'appliquer aux médecins légistes ni aux entrepreneurs de pompes funèbres[825]. Elle visait l'exécuteur testamentaire du défunt ou, à défaut, un membre de la famille. Le libellé de cette disposition signifiait également que lorsqu'un hôpital était « légalement en possession » d'un cadavre non réclamé, le directeur de cet hôpital ou un médecin avait, théoriquement, le pouvoir de consentir au prélèvement du tissu cornéen. Dans ce sens, la loi adoptait, dans un sens étroit, la notion de présomption de consentement. Dans les cas peu fréquents où un donneur non déclaré mourait dans un hôpital sans qu'on parvienne à trouver un membre de la famille légalement susceptible de réclamer le corps, la société présumait le consentement au prélèvement de la cornée[826]. Cette disposition semble avoir modifié les droits et obligations traditionnellement prévus en droit privé relativement au droit de possession des proches parents[827].

(3) Lois sur les greffes de tissus humains

Une troisième vague de réformes législatives a été suscitée par les transplantations d'organes. Au début des années soixante, on avait recours depuis près d'une dizaine

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819. *Corneal Grafting Act*, S.N.B. 1957, ch. 7.

820. *1959 Proceedings of the Forty-First Annual Meeting of the Conference of Commissioners on Uniformity of Legislation in Canada*, Victoria (C.-B.), la Conférence, 1959, p. 77.

821. Voir J.-G. CASTEL, « Some Legal Aspects of Human Organ Transplantation in Canada » (1968), 46:3 *R. du B. can.* 345, 394.

822. *Uniform Cornea Transplant Act*, précité, note 820, art. 4, par. 4.

823. *Id.*, art. 5.

824. *Ibid.*

825. *Id.*, art. 2.

826. Il convient également de signaler qu'une disposition de la loi, qui supprimait la présomption de consentement lorsque les personnes habilitées à consentir avaient des raisons de croire que le défunt se serait opposé au prélèvement (par ex. pour des motifs d'ordre religieux), ne s'étendait apparemment pas au cas des cadavres non réclamés. Voir *Uniform Cornea Transplant Act*, précité, note 820, art. 6, 2.

827. Voir *supra*, section I.

d'années déjà à la transplantation rénale pour traiter des malades en phase terminale[828]. Encore une fois, c'est en partie dans des textes étrangers qu'on trouve l'origine des dispositions législatives adoptées au Canada pour régir le prélèvement et le don d'organes. En 1961, la Grande-Bretagne a étendu la portée du *Corneal Grafting Act, 1952* pour le rendre applicable à la totalité des tissus humains, en adoptant le *Human Tissue Act, 1961*[829]. L'Ontario a suivi, en 1963, en remplaçant le *Cornea Transplant Act* par le *Human Tissue Act*[830]. Une loi uniforme canadienne a été proposée en 1963, adoptée en 1965, puis révisée en 1971 et en 1989[831].

Aujourd'hui, les principales sources du droit provincial régissant le prélèvement de parties du corps et de tissus humains consistent dans des versions provinciales du *Uniform Human Tissue Gift Act* de 1971[832]. Étant donné que la dernière révision par la Conférence sur l'uniformisation des lois est très récente (1989), elle n'a pas encore donné lieu à beaucoup de modifications législatives[833]. Le texte de 1989 comporte des précisions et des modifications importantes, mais d'une façon générale on continue à fonder sur les notions de consentement et d'altruisme les prélèvements de tissus sur des personnes vivantes ou mortes.

En ce qui a trait aux donneurs vivants, les textes de 1989 et de 1971 font tous deux reposer le don sur le consentement préalable. La loi uniforme de 1989 propose en outre une évaluation indépendante par un groupe composé de trois personnes pour le don de tissus non susceptibles de régénération et, dans le cas de mineurs, pour le don de tous tissus[834]. Pour ce qui est du don après la mort, les deux textes exigent la constatation du décès avant la transplantation ; le texte de 1989 dispose clairement que le terme « mort » désigne notamment « la mort cérébrale telle que déterminée conformément aux pratiques médicales actuelles[835]. » Dans les deux cas, on fonde d'une façon générale le prélèvement sur le consentement donné avant le décès. Si la personne n'a donné aucune directive, on a recours à la place au consentement de la « famille » du défunt[836] ; lorsqu'on ne parvient

828. Voir *supra*, ch. I, section II.C(1).

829. (R.-U.), 9 & 10 Eliz. II, ch. 54 (abrogeant le *Corneal Grafting Act, 1952*, précité, note 818).

830. S.O. 1962-63, ch. 59.

831. Pour une description de ce processus durant les années soixante-dix, voir J.-G. CASTEL, *loc. cit.*, note 821, 397-399.

832. *1971 Proceedings of the Fifty-Third Annual Meeting of the Conference of Commissioners on Uniformity of Legislation in Canada*, Jasper (Alb.), la Conférence, 1971, p. 152 [ci-après désignée « loi uniforme de 1971 »].

833. *Loi uniforme sur le don de tissus humains* (1989) [ci-après désignée « loi uniforme de 1989 »] (abrogeant la loi uniforme de 1971, précitée, note 832), CONFÉRENCE SUR L'UNIFORMISATION DES LOIS AU CANADA, *Consolidation of Uniform Acts*, Fredericton (N.-B.), la Conférence, 1990, p. 22-1. La loi uniforme de 1989 est reproduite à l'annexe B, *infra*, pp. 237-242. Voir également « Report of the Alberta Commissioners : Uniform Human Tissue Act », dans CONFÉRENCE SUR L'UNIFORMISATION DES LOIS AU CANADA, *Proceedings of the Sixty-Ninth Annual Meeting*, Victoria (C.-B.), la Conférence, 1987, p. 199.

834. Comparer loi uniforme de 1989, précitée, note 833, art. 5-7 et loi uniforme de 1971, précitée, note 832, art. 2-4. Il convient de noter que la loi de 1989 élimine l'exigence du consentement écrit.

835. Comparer loi uniforme de 1989, précitée, note 833, art. 1, 11 et loi uniforme de 1971, précitée, note 832, art. 7.

836. Comparer loi uniforme de 1989, précitée, note 833, art. 3, 4 et loi uniforme de 1971, précitée, note 832, art. 4, 5.

à retracer aucun membre de la famille, le texte de 1989 autorise le coroner à consentir au prélèvement ; le texte de 1971, en revanche, dispose que le consentement ne peut être donné ni par les coroners ni par les administrateurs d'hôpitaux, mais permet d'une manière générale aux personnes « légalement en possession de corps[837] » de le donner. Enfin, les deux lois interdisent la vente de tissus, d'organes et de parties du corps, mais pas celle du sang[838]. On s'attend que les neuf provinces et les deux territoires qui ont fondé sur le texte de 1971 leurs lois sur le don de tissus humains étudient la loi de 1989 en vue de procéder à d'éventuelles modifications législatives[839].

Au Québec, le *Code civil* établit un processus de don de tissus humains qui, sauf quelques exceptions notables, est similaire à la « loi uniforme ». Le majeur peut consentir « à l'aliénation [. . .] d'une partie de son corps [. . .] pourvu que le risque couru ne soit pas hors de proportion avec le bienfait qu'on peut en espérer[840] ». On peut également donner des directives quant à la disposition de ses restes après sa mort ; à défaut de telles directives, le consentement peut être donné par le conjoint ou le parent le plus rapproché[841]. Le *Code civil* prévoit une exception restreinte à ces règles — dans les situations urgentes, le médecin est autorisé à prélever les organes ou les tissus d'une personne qui vient de mourir sans obtenir le consentement normalement requis :

> Ce consentement n'est pas nécessaire lorsque deux médecins attestent par écrit l'impossibilité de l'obtenir en temps utile, l'urgence de l'intervention et l'espoir sérieux de sauver une vie humaine[842].

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837. Comparer loi uniforme de 1989, précitée, note 833, par. 4(4) et loi uniforme de 1971, précitée, note 832, art. 5.

838. Comparer loi uniforme de 1989, précitée, note 833, art. 15, 1 et loi uniforme de 1971, précitée, note 832, art. 10, 1.

839. Voir *Human Tissue Gift Act*, R.S.A. 1980, ch. H-12 ; *Human Tissue Gift Act*, R.S.B.C. 1979, ch. 187 ; *Loi sur les tissus humains*, L.M. 1987-88, ch. 39 [ci-après LTHM] ; *Loi sur les tissus humains*, L.R.N.-B. 1973, ch. H-12 ; *The Human Tissue Act, 1971*, S.N. 1971, No 66 ; *Human Tissue Ordinance*, R.O.N.W.T. 1974, ch. H-4 ; *Human Tissue Gift Act*, R.S.N.S. 1989, ch. 215 ; *Human Tissue Gift Act*, R.S.O. 1980, ch. 210 ; *Human Tissue Gift Act*, R.S.P.E.I. 1988, ch. H-13 ; *The Human Tissue Gift Act*, R.S.S. 1978, ch. H-15 ; *Human Tissue Gift Act*, R.S.Y.T. 1986, ch. 89. Voir également « Report of the Alberta Commissioners », *loc. cit.*, note 833.

840. C.c., art. 20.

841. C.c., art. 21, 22. L'article 21 est ainsi rédigé :

> Le majeur peut par écrit régler les conditions de ses funérailles et le mode de disposition de son cadavre. Le mineur doué de discernement le peut également avec le consentement de son père ou de sa mère. Le consentement doit être donné par écrit ; il peut être pareillement révoqué. À défaut de directives du défunt, on s'en remet à l'usage.

842. C.c., art. 22 :

> Un médecin peut effectuer un prélèvement sur un cadavre si, à défaut de directives du défunt, il obtient le consentement du conjoint ou du parent le plus rapproché. Ce consentement n'est pas nécessaire lorsque deux médecins attestent par écrit l'impossibilité de l'obtenir en temps utile, l'urgence de l'intervention et l'espoir sérieux de sauver une vie humaine. La mort du donneur doit être constatée par deux médecins qui ne participent en aucune manière à ce prélèvement ni à une transplantation.

Enfin, le Code exige que tout don de tissus humains fait par des donneurs vivants soit gratuit, sauf s'il s'agit d'un tissu susceptible de régénération[843].

Considérés comme un tout, le *Code civil* du Québec et les « lois uniformes » établissent d'une manière générale le régime en vigueur au Canada, en ce qui a trait au don et au prélèvement de tissus et d'organes humains au Canada. Premièrement, ce régime est d'une manière générale fondé sur le consentement du donneur, ou de sa famille lorsqu'il n'a pas exprimé sa volonté. Il existe des exceptions. Le *Code civil* autorise les médecins à effectuer, sans le consentement normalement requis, des prélèvements sur un cadavre lorsque l'intervention est urgente. Les lois sur l'anatomie établissent, quant au prélèvement, une présomption de consentement dans le cas de cadavres non réclamés. La loi uniforme de 1989 semble proposer une règle semblable en ce qui a trait au prélèvement de tissus et d'organes sur les cadavres non réclamés[844]. En Alberta, au Manitoba, en Ontario, à l'Île-du-Prince-Édouard et en Nouvelle-Écosse, le législateur a établi une présomption de consentement à l'égard du prélèvement de l'hypophyse sur les cadavres confiés au coroner ou au médecin légiste, si ces derniers ne sont informés d'aucune objection à ce prélèvement[845]. Des dispositions semblables ont été adoptées, au sujet des tissus cornéens, en Saskatchewan, à l'Île-du-Prince-Édouard et au Manitoba[846]. Si les présomptions de consentement qui existent dans plusieurs provinces sont limitées à certains tissus et à certaines circonstances, on pourrait néanmoins s'en inspirer pour effectuer des réformes législatives de large portée visant à réduire la pénurie qui existe en ce qui concerne certains tissus et organes[847].

Deuxièmement, l'importance attachée à la notion de consentement montre que la société canadienne a su, jusqu'à présent, concilier l'intérêt des donneurs et de leur famille, et celui des receveurs potentiels. Par ailleurs, les dispositions législatives en vigueur sont en grande partie compatibles avec l'attribution des intérêts, des droits et des obligations

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843. C.c., art. 20 :

> Le majeur peut consentir par écrit à l'aliénation entre vifs d'une partie de son corps ou à se soumettre à une expérimentation, pourvu que le risque couru ne soit pas hors de proportion avec le bienfait qu'on peut en espérer. Le mineur doué de discernement le peut également avec l'autorisation d'un juge de la Cour supérieure et le consentement du titulaire de l'autorité parentale à condition qu'il n'en résulte pas un risque sérieux pour sa santé. *L'aliénation doit être gratuite à moins que son objet ne soit une partie du corps susceptible de régénération.* Le consentement doit être donné par écrit ; il peut être pareillement révoqué. [Mis en italiques par nos soins.].

Comparer projet de loi 125, précité, notes 380, 473.

844. Voir, *supra*, le texte accompagnant la note 837. Cette disposition est le pendant de la présomption de consentement établie récemment à l'égard des médecins légistes dans des modifications apportées à des lois américaines portant sur le prélèvement d'organes sur des cadavres. Voir *infra*, notes 1004 et 1007.

845. Voir *Fatality Inquiries Act*, R.S.A. 1980, ch. F-6, art. 27 ; LTHM, précitée, note 839, art. 6.1 ; *Coroners Act*, R.S.O. 1980, ch. 93, art. 29 ; *Human Tissue Gift Act*, S.P.E.I. 1980, ch. 27 ; *Fatality Inquiries Act*, R.S.N.S. 1989, ch. 164, art. 20. La mise au point de l'hormone de croissance humaine à partir de l'ADN recombinant semble remettre en question l'utilité de ces dispositions. Voir *supra*, pp. 20-21.

846. Voir *Coroners Amendment Act, 1984*, S.S. 1983-84, ch. 32 ; LTHM, précitée, note 839, par. 7(2) ; *Cornea Transplant Act*, R.S.P.E.I. 1974, ch. C-22.

847. Voir Margaret A. SOMERVILLE, « "Procurement" vs. "Donation" — Access to Tissues and Organs for Transplantation » (1985), 17:6 (Suppl. 4) *Transplant. Proc.* 53.

prévue par les règles de droit civil régissant la possession. La pénurie d'organes et de tissus s'accentuant ou devenant critique[848], la possibilité de sauver des vies grâce à l'augmentation du nombre d'organes disponibles tend à prendre le pas sur certains des principes qui sous-tendent le système actuel : autonomie de l'être humain, caractère volontaire de l'aliénation de tissus et d'organes, respect dû aux morts. Durant les deux décennies qui se sont écoulées depuis l'instauration officielle de ce régime, les progrès de la science médicale ont entraîné une augmentation de la demande d'organes et de tissus humains. Les transplantations du cœur et du foie sont devenues des thérapies efficaces, au même titre que les transplantations rénales et cornéennes. Plus de deux mille cinq cents personnes étaient inscrites sur les diverses listes d'attente à la fin de 1989, ce qui semble indiquer l'existence d'une pénurie nationale. Si l'on conclut que ces chiffres traduisent les limites du système actuel, l'intérêt de la société à l'égard de la préservation de la vie et de la santé nous forcera à repenser ce système, voire à le réformer. On aura ainsi l'occasion de réaffirmer certains principes, certains droits et certaines valeurs déjà établis, de les modifier, ou d'en revoir l'importance relative.

Troisièmement, le régime actuel de prélèvement de tissus et d'organes repose dans une large mesure sur l'éthique du don. La vente des organes et des tissus humains est, en règle générale, interdite au Canada. Toutefois, si la pénurie actuelle tient en partie au respect absolu du principe de l'altruisme, des mesures incitatives non altruistes, notamment le versement d'argent ou des avantages fiscaux, pourraient faire augmenter l'offre[849]. Étant donné les valeurs et les intérêts en cause, toute réforme du régime actuel revêtirait sans doute une importance nationale.

Le régime en vigueur comporte par ailleurs certaines ambiguïtés sur les plans pratique et juridique. Si la famille d'une personne qui vient de mourir s'oppose au prélèvement d'organes envisagé par les médecins, bien que la personne en question ait signé sa carte de donneur, la volonté de la famille doit-elle, en droit, prévaloir[850] ? Le respect de l'autonomie de l'être humain porte sans doute à conclure que les directives données par le défunt devraient l'emporter[851] ; des précisions législatives visant à dissiper cette incertitude donneraient aux donneurs et aux équipes de transplantation une plus grande certitude quant à la portée du consentement donné expressément par l'intéressé[852]. Pourtant, même si le législateur permettait ainsi aux médecins d'agir en conformité avec la volonté du défunt, les objections persistantes de la famille n'auront-elles ou ne devraient-elles pas avoir pour conséquence de dissuader l'hôpital de le faire ? Les établissements désireux d'éviter de tels conflits pourraient en effet refuser d'agir en dépit du pouvoir qui leur serait conféré. Le droit a ses limites.

Certaines ambiguïtés existent aussi dans le domaine de la vente des tissus. Les dispositions du *Code civil* du Québec exigeant l'aliénation gratuite des tissus non susceptibles

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848. Voir *supra*, ch. I.

849. Voir R.D. ROBERTS et M.J. WOLKOFF, *loc. cit.*, note 492.

850. Voir Bill TRENT, « An Old Woman, Prepared to Die: What Should the ER Doctors Do? » (1989), 141:5 *Journal de l'Association médicale canadienne* 456.

851. Voir *supra*, notes 268, 325.

852. Voir loi uniforme de 1989, précité, note 833, art. 9.

de régénération par des donneurs *vivants* ont-elles une incidence sur la vente d'organes prélevés sur des donneurs *décédés ?* Celles qui portent sur la nullité sont-elles, autant que les sanctions pénales prévues à la loi uniforme de 1971, susceptibles d'empêcher la vente d'organes ? Doit-on interdire la publicité concernant l'achat ou l'offre d'organes ? Ni le *Code civil* ni la loi uniforme de 1971 ne traitent de cette question.

Quel est le sens juridique précis du mot « vente » dans la loi uniforme ? Par exemple, le texte uniforme de 1989 propose d'interdire et de punir (amende de 100 000 $ ou un an de prison, ou les deux) la vente des tissus :

> Nul ne peut acheter ou vendre, directement ou indirectement, un tissu, un corps ou une partie de corps humain, ou en faire le commerce à des fins de transplantation, d'enseignement médical, de recherche scientifique ou à des fins thérapeutiques[853].

Le texte de 1989 supprime la définition de la vente établie en common law (échange « à titre onéreux »). Comme il ne contient aucune définition, il semble confier aux tribunaux le soin de déterminer la signification juridique précise du concept de la vente, s'agissant de tissus humains. Le Manitoba et de nombreux pays étrangers se sont écartés de cette voie en définissant expressément la vente dans le cadre de la réforme effectuée.

La loi uniforme de 1989 apporte par ailleurs des précisions sur la portée de l'interdiction de la vente. La nouvelle définition donnée au mot « tissu » exclut expressément du champ d'application de la loi le sperme et les autres substances reproductives humaines[854]. Le législateur est par le fait même invité, soit à adopter un texte spécifique sur la vente des tissus reproductifs humains, soit à laisser les principes de common law régir la question[855]. Il semble également que la nouvelle définition du mot « tissu » abolisse les ambiguïtés touchant la vente des tissus susceptibles de régénération[856], parce que le texte de 1989 interdit la vente de tous les tissus humains et de toutes les parties du corps, sauf le sang, les gamètes ou les produits de la conception[857].

Toutefois, même ces précisions n'empêcheront sans doute pas les progrès de la médecine de susciter des interrogations sur le sens et la portée de l'interdiction de la vente

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853. *Id.*, par. 15(1).

854. Voir loi uniforme de 1971, précitée, note 832, art. 1.

855. Voir loi uniforme de 1989, précitée, note 833, art. 1.

856. Les dispositions pertinentes de la loi uniforme de 1971 concernant l'interdiction de la vente sont reproduites, à l'annexe B, *infra*, p. 235. Certains estiment que la prohibition figurant à l'art. 10 ne s'applique qu'aux tissus non susceptibles de régénération, vu la définition du mot « tissu » figurant à l'article 1 (de laquelle est exclu tout « tissu se renouvelant par un processus naturel de régénération »). Ils en concluent que la peau, la moelle osseuse, les os et les autres tissus similaires échappent à l'interdiction. D'autres pensent en revanche que les termes utilisés à l'art. 10 prohibent la vente des tissus susceptibles de régénération comme des autres. On peut faire valoir que les mots « un tissu destiné à une transplantation » renvoient aux tissus susceptibles ou non de régénération, et que la portée de cette disposition n'est pas restreinte par la définition du mot tissu. Si les rédacteurs entendaient exclure tous les tissus susceptibles de régénération, la disposition n'aurait pas exclu, de manière explicite et redondante, le sang. On estimera alors que l'expression « à l'exception du sang et ses composants », vu les termes utilisés et la structure, indique une intention large. Loi uniforme de 1971, précitée, note 832.

857. Loi uniforme de 1989, précitée, note 833, art. 1, 15.

des tissus. Un État américain a décidé de soustraire les lignées cellulaires à cette interdiction, ce qui amène à se demander si la prohibition de la vente des tissus figurant dans la « loi uniforme » s'applique aux entités cellulaires ou infra-cellulaires[858]. En outre, comme les textes de 1971 et de 1989 n'interdisent expressément que la vente à « des fins thérapeutiques, pour l'enseignement de la médecine ou pour la recherche scientifique », ne pourrait-on conclure qu'elles ne s'opposent pas à la vente à des fins plus commerciales, comme la préparation de cosmétiques[859] ? Une province canadienne, notamment, a préféré interdire la vente des tissus « pour quelque fin que ce soit[860] ».

(4) Réformes législatives provinciales

On a tenté par des initiatives législatives récentes de remédier à certains des problèmes et des lacunes dont il vient d'être fait état. Outre l'élaboration de la loi uniforme de 1989, des actions ont été prises par le législateur en Ontario, au Manitoba et au Québec[861]. Par exemple, l'Ontario et le Manitoba ont établi des dispositions législatives et réglementaires correspondant à la réforme réalisée aux États-Unis en matière de don d'organes. En 1990, l'Ontario a commencé à obliger les hôpitaux à mettre sur pied des mécanismes susceptibles d'encourager le don de tissus et d'organes humains, notamment des protocoles permettant de repérer les donneurs potentiels et de les sensibiliser, ainsi que les membres de leur famille, à la possibilité de tels dons[862].

En 1987, le Manitoba modifiait sa *Loi sur les tissus humains*, à la suite d'un rapport présenté par la Commission de réforme du droit du Manitoba[863]. Une des principales recommandations de la Commission concernait l'adoption du principe de l'encouragement au don volontaire et le rejet de la vente d'organes. Se fondant sur des données montrant que 72 % des proches parents des donneurs potentiels consentent au prélèvement lorsqu'on leur demande, la Commission recommandait aux hôpitaux d'adopter des mécanismes propres à garantir que cette demande soit automatique, de façon que les familles aient dans tous les cas l'occasion de donner ce consentement[864]. Pour la Commission, cette solution semblait moins susceptible de porter atteinte aux intérêts affectifs et religieux des familles des donneurs potentiels que, par exemple, la présomption de consentement[865].

En outre, réaffirmant l'interdiction frappant la vente de tissus et d'organes humains, la Commission de réforme du droit du Manitoba recommandait que soit reconnue, dans

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858. Comparer Minn. Stat. Ann. art. 145.422 (West 1988 Supp.) et loi uniforme de 1989, précitée, note 833, art. 15, 1.

859. Voir loi uniforme de 1971, précitée, note 832, art. 10 ; loi uniforme de 1989, précitée, note 833, art. 12 ; et B.M. DICKENS, *loc. cit.*, note 414, 166.

860. Pour un examen des réformes législatives du Manitoba, voir *infra*, section III.B(4).

861. Voir loi uniforme de 1989, précitée, note 833. Pendant la préparation du présent document, la Nouvelle-Écosse a modifié sa loi sur le don de tissus humains, voir S.N.S. 1991, ch. 13.

862. O. Reg. 34/90 (modifiant le règlement 518/88 de la *Loi sur les hôpitaux publics*).

863. Voir LTHM, précitée, note 839. Voir également CRDM, *op. cit.*, note 491.

864. Voir CRDM, *op. cit.*, note 491, pp. 28, 54-57.

865. Voir *id.*, p. 35, où l'on analyse les contestations fondées sur la Charte en ce qui concerne les présomptions de consentement établies dans la loi.

la définition du mot « vente », la distinction entre le fait d'interdire l'échange de tissus humains et le fait d'interdire le remboursement des dépenses connexes raisonnables[866]. En effet, même si la société trouve répugnant le fait que des personnes puissent tirer un profit pécuniaire de l'échange de parties du corps et de substances corporelles, une interdiction absolue des « échanges à titre onéreux » risquerait d'entraver les dons qui entraînent des frais importants liés au déplacement, au prélèvement, à la conservation[867]. Une définition où l'on distingue contrepartie pécuniaire et remboursement des frais raisonnables nuirait sans doute moins aux dons entraînant des frais. C'est pourquoi la loi adoptée dans la foulée du rapport exclut de la définition des termes « vendre ou acheter » le remboursement des frais connexes raisonnables[868]. Elle interdit par contre la vente de tissus humains « pour quelque fin que ce soit[869] ».

Certaines modifications aux dispositions du *Code civil* relatives à la transplantation d'organes ont été proposées[870].

IV. Droit constitutionnel et droits de la personne

Depuis l'entrée en vigueur, en 1982, de la *Charte canadienne des droits et libertés*[871], les mesures prises par les autorités publiques pour réglementer le prélèvement des tissus humains doivent satisfaire à une nouvelle exigence : elles doivent s'accorder avec les droits et libertés de la personne qui font l'objet d'une protection constitutionnelle.

L'adoption de la Charte étant récente, on commence seulement à en saisir l'incidence sur de nombreux aspects de la vie sociale au Canada. C'est ce qui se passe dans le cas du prélèvement de tissus humains, où d'épineux problèmes se posent à propos des droits de la personne. Peut-on dire que les droits fondamentaux, et notamment le droit à la liberté, comportent le droit, constitutionnellement protégé, de ne pas se voir imposer par l'État la mutilation du corps d'un proche parent qui vient de mourir[872] ? La liberté embrasse-t-elle le droit constitutionnel de vendre des substances corporelles[873] ? L'interdiction de la publicité concernant la vente d'organes porte-t-elle atteinte au droit à la liberté

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866. Voir CRDM, *op. cit.*, note 491, pp. 111-112.

867. Voir *supra*, section I.C, « Vente de produits du corps humain ».

868. LTHM, précitée, note 839, par. 15(2), 15(3), 15(4).

869. *Id.*, par. 15(2).

870. Voir projet de loi 125, précité, note 380.

871. Partie I de la *Loi constitutionnelle de 1982* [annexe B de la *Loi de 1982 sur le Canada* (1982, R.-U., ch. 11)] [ci-après désignée Charte].

872. Voir *Arnaud* c. *Odom*, 870 F. 2d 304 (5th Cir. 1989) (le fait qu'un médecin légiste procède, sans permission, à des expériences sur les cadavres de nouveau-nés ne porte pas atteinte aux droits constitutionnels des parents). Comparer *Kirker*, précité, note 403.

873. Voir Karen L. JOHNSON, « The Sale of Human Organs: Implicating a Privacy Right » (1987), 21 *Val. U. L. Rev.* 741. À cet égard, il convient de signaler que dans certains pays on restreindrait l'interdiction aux ventes faites après le décès. Voir, par exemple, UAGA, *infra*, note 1004, art. 10.

d'expression[874] ? Le corps d'un patient qui vient de mourir est-il visé par les garanties énoncées dans la Charte ? Les droits constitutionnels s'éteignent-ils au moment du décès ?

C'est dans la jurisprudence relative à la Charte que s'élaborent les réponses à ces questions. Les techniques de remplacement de tissus ont été traitées dans certaines causes récentes[875], mais jusqu'ici les tribunaux n'ont pas été appelés à se pencher directement sur les aspects constitutionnels de la transplantation d'organes au Canada. La situation semble être la même en ce qui concerne les dispositions de la Convention européenne des droits de l'homme[876]. Néanmoins, il est possible d'examiner certains principes fondamentaux de la Charte pour voir comment ils peuvent s'appliquer aux textes régissant le prélèvement et l'aliénation des tissus humains. En outre, les mesures prises aux États-Unis pour remédier à la pénurie d'organes et de tissus ont suscité ces dernières années plusieurs litiges où il était question des dispositions établissant une présomption de consentement. On peut, en s'inspirant des décisions en cause, préciser la portée des principes énoncés dans la Charte. Comme on pouvait s'y attendre, l'analyse révèle l'existence de fréquentes tensions entre, d'une part, des droits individuels — liberté religieuse, protection de la vie privée et de l'intégrité corporelle, droit d'être traité d'une manière équitable, et, d'autre part, les intérêts de l'État ou de la société au chapitre de la préservation de la vie et de la protection de la santé publique.

A. Mesures prises par les pouvoirs publics

La Charte s'applique d'une manière générale aux actes des pouvoirs publics[877], soit à l'exercice du pouvoir législatif, exécutif et administratif à l'échelon fédéral comme à l'échelon provincial[878]. Ainsi, les dispositions législatives sur les dons d'organes doivent être conformes à la Charte, tout comme les actes des coroners et des médecins légistes provinciaux. Une récente décision de la Cour suprême donne à penser que la politique interne des hôpitaux canadiens n'est d'une manière générale pas visée par la Charte, mais elle n'en doit pas moins être compatible avec les lois provinciales sur les droits de la personne[879]. La politique des hôpitaux en matière de prélèvement d'organes et les mesures

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874. Voir *Rocket* c. *Collège royal des chirurgiens dentistes d'Ontario*, [1990] 2 R.C.S. 232.

875. Voir par exemple, *Dyment*, précité, note 424 et *Re L.D.K.* c. *Children's Aid Society of Metropolitan Toronto*, *infra*, note 883.

876. Pour des précisions sur la Convention européenne, voir *infra*, note 964.

877. Voir le paragraphe 32(1) de la Charte :

> 32.(1) La présente charte s'applique :
>
> *a*) au Parlement et au gouvernement du Canada, pour tous les domaines relevant du Parlement, y compris ceux qui concernent le territoire du Yukon et les territoires du Nord-Ouest ;
>
> *b*) à la législature et au gouvernement de chaque province, pour tous les domaines relevant de cette législature.

878. Voir *SDGMR* c. *Dolphin Delivery Ltd.*, [1986] 2 R.C.S. 573.

879. Voir *Stoffman* c. *Vancouver General Hospital*, [1990] 3 R.C.S. 483, 533-548. Voir également *Peters* c. *University Hospital Board*, [1983] 5 W.W.R. 193 (C.A. Sask.) et *Code des droits de la personne (1981)*, L.O. 1981, ch. 53, art. 1.

qu'ils prennent à cet égard doivent donc tout de même répondre aux impératifs fondamentaux des droits de la personne.

B. Intégrité corporelle et protection de la vie privée

La Charte protège l'intégrité physique et la vie privée, en consacrant le droit de chacun « à la vie, à la liberté et à la sécurité de sa personne[880] », et en interdisant « les fouilles, les perquisitions ou les saisies abusives[881] » ainsi que les « traitements [...] cruels et inusités[882] ». Par exemple, un tribunal a jugé qu'une transfusion de sang, pratiquée sans autorisation, avait porté atteinte à l'intégrité physique et à la sécurité de la personne d'un enfant de 12 ans[883]. Et dans le contexte du droit pénal, la Cour suprême du Canada s'est appuyée sur la disposition de la Charte relative aux fouilles, perquisitions et saisies pour conclure que le prélèvement d'un échantillon de sang sur un patient inconscient, sans son consentement, avait constitué une atteinte à sa vie privée et à la dignité de sa personne[884]. La Cour a déjà jugé que le droit de chacun à la sécurité de sa personne comprend la protection de son intégrité physique et mentale[885]. D'autres tribunaux canadiens ont déclaré que le fait pour l'État d'incarcérer une personne et de lui refuser par la suite l'accès aux services de santé essentiels constituait un traitement cruel et inusité ou portait atteinte au droit à la sécurité de sa personne[886]. Ces principes pourraient s'appliquer aux techniques de remplacement des tissus lorsque leur utilisation s'avère indiquée du point de vue médical[887].

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880. Voir l'art. 7 de la Charte.

881. *Id.*, art. 8 et par. 24(2).

882. *Id.*, art. 12.

883. *Re L.D.K.* c. *Children's Aid Society of Metropolitan Toronto* (1986), 48 R.F.L. (2e) 164 (C. famille, Ont.).

884. Voir *Dyment*, précité, note 424 et le texte l'accompagnant.

885. Voir *R.* c. *Morgentaler*, [1988] 1 R.C.S. 30, 53.

886. Voir *R.* c. *Downey* (1990), 42 C.R.R. 286 (C. distr. Ont.) (où le tribunal a conclu que le fait de priver un détenu atteint du SIDA d'un traitement médical essentiel constituait un traitement cruel et inusité) ; *McNamra* c. *Caros*, [1978] 1 C.F. 451 (Sect. 1re inst.) ; *Collin* c. *Lussier*, [1983] 1 C.F. 218, 236-238 (le droit d'un prisonnier à la sécurité de la personne comporte le droit à la protection de son intégrité physique et le droit aux services médicaux et aux choses nécessaires à la vie) ; décision infirmée en partie pour d'autres motifs, [1985] 1 C.F. 124 (Sect. d'app.). La loi donne aussi aux détenus fédéraux le droit de recevoir les « soins [...] médicaux essentiels ». Voir *Règlement sur le service des pénitenciers*, précité, note 793, art. 16. Aux États-Unis, la clause relative au *due process*, pendant de la clause canadienne sur le droit de chacun à la sécurité de la personne, garantit aux prévenus les soins médicaux nécessaires. Voir *City of Revere* c. *Massachusetts General Hospital*, 463 U.S. 239 (1983). Voir également *Thompson* c. *City of Portland*, 620 F. Supp. 482 (D.C. Me. 1985). En ce qui concerne, toujours aux États-Unis, les individus reconnus coupables et incarcérés, [TRADUCTION] « une indifférence délibérée quant aux besoins médicaux sérieux d'un prisonnier [constitue] une peine cruelle et inusitée. ». *Estelle* c. *Gamble*, 429 U.S. 97 (1976), 103-104 ([TRADUCTION] « Un détenu ne peut que s'en remettre aux autorités carcérales pour ses besoins médicaux ; si les autorités négligent de s'en occuper, ces besoins ne seront pas comblés. Dans les pires cas, un tel refus d'agir peut réellement causer une "torture physique ou une mort lente" [...] Dans les cas moins sérieux, le refus de prodiguer les soins médicaux peut causer des douleurs et des souffrances, et personne ne prétend que celles-ci auraient une quelconque utilité du point de vue de la pénologie. [...] Le fait de causer de telles souffrances inutiles ne peut s'accorder avec les normes contemporaines de la décence »). Pour des observations générales sur les droits des prisonniers au regard de la Charte, voir A. Wayne MACKAY, « Inmates Rights: Lost in the Maze of Prison Bureaucracy » (1987-88), 11 *Dalhousie L.J.* 698.

887. *Thompson* c. *City of Portland*, précité, note 886 (le refus de fournir les soins médicaux nécessaires à une personne ayant subi une greffe qui est détenue par la police contrevient à la disposition constitutionnelle relative au *due process*).

Le droit de chacun à la sécurité de sa personne protège aussi bien les donneurs vivants que les receveurs potentiels. Certains auteurs se demandent s'il s'applique également aux donneurs décédés ou, autrement dit, si le prélèvement non autorisé d'organes sur un cadavre y porte atteinte[888]. La question peut se poser avec une acuité particulière à propos de l'exclusion, du champ d'application des présomptions légales de consentement, des mineurs ou des personnes atteintes de déficience mentale. En effet, ces présomptions ne sont en général pas absolues, toute personne pouvant manifester son opposition au prélèvement de ses organes après son décès. Mais l'application de telles dispositions aux personnes incapables de véritablement exprimer leur volonté risquerait de les priver de la possibilité, accordée aux autres personnes, de veiller à la protection de leur intégrité physique ou de la sécurité de leur personne après la mort[889].

Même à supposer que le droit de chacun à la sécurité de sa personne s'applique à la fois aux donneurs vivants et aux donneurs décédés, les atteintes portées à ce droit par une loi ou une politique de l'État ne sont pas nécessairement contraires à la Charte. Car si la société attache beaucoup de prix au droit à l'intégrité corporelle[890], il ne s'agit pas d'un droit absolu. Il peut être y être porté atteinte en conformité avec les principes de la justice fondamentale, ou dans des limites raisonnables « dont la justification [peut] se démontrer dans le cadre d'une société libre et démocratique[891] ». L'équilibre entre les droits de la personne et les besoins fondamentaux de la démocratie exige, selon la jurisprudence de la Cour suprême du Canada, que le gouvernement démontre : (1) l'existence d'un objectif législatif important se rapportant à « des préoccupations urgentes et réelles » ; (2) la proportionnalité — les moyens choisis pour promouvoir l'objectif du gouvernement doivent avoir un lien rationnel avec celui-ci, porter le moins possible atteinte au droit en question et témoigner d'une proportionnalité entre l'objectif du gouvernement et les effets réels des moyens choisis pour promouvoir cet objectif[892]. Il s'agit de faire en sorte que toute atteinte aux droits constitutionnellement garantis se fasse de la façon qui restreint le moins les libertés fondamentales[893].

Des principes analogues ont orienté l'analyse des tribunaux américains appelés à déterminer si les pratiques et les dispositions législatives ayant trait à la présomption de consentement portaient atteinte aux droits de la personne. Dans les quelques affaires où le problème s'est directement posé, les autorités judiciaires ont confirmé la constitutionnalité de la pratique ou des dispositions en cause. Certains tribunaux ont divergé d'opinion sur la question de savoir si le droit sous-jacent concerné — par exemple, dans le cas d'une atteinte au droit de possession attribué aux proches parents en ce qui a trait à l'inhumation —

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888. Voir E.I. PICARD, *op. cit.*, note 364, p. 132, n. 649.

889. En Belgique, les règles relatives à la présomption de consentement sont applicables aux mineurs, en France elles ne le sont pas ; à ce sujet, voir le texte accompagnant les notes 961-962, *infra*.

890. Voir *Eve*, précité, note 362.

891. Voir les art. 7, 1 de la Charte.

892. *R.* c. *Oakes*, [1986] 1 R.C.S. 103, 139. Voir en général Peter W. HOGG, « Section 1 Revisited » (1990), 1 *Nat'l J. Const. L.* 1.

893. Voir Peter W. HOGG, *Canadian Constitutional Law of Canada*, 2e éd., Toronto, Carswell, 1985, pp. 686-687. Laurence H. TRIBE, *American Constitutional Law*, 2e éd., Mineola (N.Y.), Foundation, 1988, pp. 1032, 1256, 1377.

bénéficiait bel et bien d'une protection constitutionnelle[894]. D'autres tribunaux ont souligné que les dispositions dont le champ d'application est clairement circonscrit répondent d'une manière raisonnable au souci de l'État de promouvoir la santé et la préservation de la vie :

> [TRADUCTION]
> L'étude de l'article 732.9185 révèle l'existence de certaines garanties qui visent apparemment à limiter le prélèvement des cornées aux cas où l'intérêt du public est le plus grand et où les répercussions sur les proches parents sont les moindres : on ne peut prélever les cornées que si la personne décédée relève de la compétence du médecin légiste. [...]
>
> En conclusion, nous croyons que l'article 732.9185 est conforme à la Constitution parce qu'il favorise de façon rationnelle un objectif légitime de l'État, celui de redonner la vue à des personnes aveugles. En arrivant à cette conclusion, nous signalons que les règles régissant le prélèvement de tissus humains effectué en vue d'une transplantation soulèvent des problèmes d'ordre moral, éthique, théologique, philosophique et économique qu'il n'est pas facile d'analyser dans le cadre juridique traditionnel[895].

C. Liberté de conscience et de religion

Cette nécessité de veiller à ce que les moyens utilisés soient circonscrits, et proportionnés à l'objectif poursuivi, est sans doute tout aussi grande lorsque les mesures prises par l'État pour favoriser les transplantations portent atteinte à des croyances religieuses. La Charte[896] protège le libre exercice de la religion :

> La liberté doit sûrement reposer sur le respect de la dignité et des droits inviolables de l'être humain. Le concept de la liberté de religion se définit essentiellement comme le droit de croire ce que l'on veut en matière religieuse, le droit de professer ouvertement des croyances religieuses sans crainte d'empêchement ou de représailles et le droit de manifester ses croyances religieuses par leur mise en pratique et par le culte ou par leur enseignement et leur propagation[897].

Ainsi, le fait de forcer un Témoin de Jéhovah à recevoir une transfusion sanguine, ce que sa religion lui interdit, peut constituer une atteinte à ses croyances religieuses[898]. La religion juive orthodoxe interdit quant à elle la dissection des cadavres et les

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894. Voir *Brotherton* c. *Cleveland*, 923 F. 2d 477 (6th Cir. 1991) ; *Georgia Lions Eye Bank* c. *Lavant*, 335 S.E. 2d 127 (Ga. 1985), cert. refusé 475 U.S. 1084 (1986) ; *Tillman* c. *Detroit Receiving Hospital*, 360 N.W. 2d 275 (Mich. App. 1984). Comparer Erik S. JAFFE, « She's Got Bette Davis ['s] Eyes : Assessing the Nonconsensual Removal of Cadaver Organs Under the Takings and Due Process Clauses » (1990), 90 *Colum. L. Rev.* 528 et Donald R. MCNEIL, « The Constitutionality of "Presumed Consent" for Organ Donation » (1989), 9 *Hamline J. Pub. L. & Pol'y* 343.

895. *State* c. *Powell*, 497 So. 2d 1188, 1191, 1193-1194 (Fla. 1986), cert. refusé 481 U.S. 1059.

896. Alinéa 2*a*).

897. *R.* c. *Big M Drug Mart Ltd.*, [1985] 1 R.C.S. 295, 336.

898. Voir *L.D.K.*, précité, note 883. Voir également *Malette*, précité, note 363. Une cause américaine récente : *Public Health Trust of Dade County* c. *Wons*, 541 So. 2d. 96, 102 (Fla. 1989) ([TRADUCTION] « M^me^ Wons ne voulait pas mourir, et ne veut pas mourir si sa maladie devait la frapper de nouveau. Cependant, en

interventions semblables[899]. La doctrine de certaines religions de l'Extrême-Orient s'oppose rigoureusement à toute mutilation du cadavre, notamment au prélèvement d'organes et à l'autopsie[900]. Chez certains peuples autochtones, ainsi que dans l'islam orthodoxe et le shintoïsme, on interdit le prélèvement des organes après la mort ou la greffe de tissus prélevés sur des cadavres[901].

De telles croyances ne sont sans doute pas très répandues au Canada. Faut-il pour cela refuser à la minorité de personnes convaincues que l'intégrité du cadavre est indispensable au passage dans l'autre vie, le droit de voir cette conviction respectée par la société[902] ? Certainement pas, car la Charte vise notamment à assurer à tous — qu'ils appartiennent à la majorité ou à la minorité — la liberté de conscience et de religion[903]. En fait, il y aurait sans doute lieu d'accorder une plus grande protection aux personnes dont les croyances religieuses sont peu répandues dans la société, pour combattre la contrainte et favoriser une véritable égalité sur le plan de l'autonomie religieuse[904]. C'est ce qui, semble-t-il, a incité le Bureau du médecin légiste en chef de l'Alberta à exclure diverses minorités religieuses — Hindous, adeptes de la Science chrétienne, juifs orthodoxes, musulmans, Indiens du Canada, métis, peuples inuit — de l'application d'une politique, en vigueur depuis cinq ans, suivant laquelle on demande automatiquement aux membres de la famille s'ils souhaitent que les tissus du défunt soient prélevés[905]. On a voulu, selon toute vraisemblance, répondre aux exigences de la Charte et favoriser le libre exercice de la religion[906].

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raison de ses fortes convictions religieuses, elle a choisi d'affronter la mort plutôt que d'accepter une transfusion de sang. [...] Toutefois, en tant que parent, elle doit également penser à l'exemple qu'elle donne à ses enfants, se demander comment elle pourrait leur apprendre à suivre ce qu'elle croit être la loi de Dieu, si elle-même ne le fait pas. Son choix n'est pas facile, mais c'est son choix. La Cour n'a pas à juger du caractère raisonnable ou de la validité de ses croyances. En l'absence d'un intérêt contraire réellement irrésistible de l'État, la loi doit protéger son droit de faire ce choix. »).

899. *Atkins* c. *Medical Examiner*, 418 N.Y.S. 2d 839 (1979) ; *Kohn*, précité, note 404. Voir également D.W. Weiss, « Organ Transplantation, Medical Ethics, and Jewish Law » (1988), 20:1 (Suppl. 1) *Transplant. Proc.* 1071.

900. Voir *You Vang Yang* c. *Sturner*, 728 F. Supp. 845, 846 (D.R.I. 1990) (au sujet de la loi sur les autopsies et des pratiques religieuses des Hmong) désistement, 750 F. Supp. 558.

901. Voir *Begay* c. *State*, 723 P. 2d 252 (N.M. App. 1985) (les lois sur les autopsies s'opposent aux croyances religieuses des autochtones américains). Pour les musulmans orthodoxes, le Coran, traditionnellement reconnu comme la parole même de Dieu et une source majeure du droit islamique, interdit le prélèvement d'organes sur des cadavres ou leur transplantation. Voir T.K.K. Iyer, *loc. cit.*, note 319 ; Claude Jacquinot, « Sur les prélèvements d'organes », Gaz. Pal. 1979. 1ère sem. Doctr.57.

902. Voir John Dwight Ingram, « State Interference with Religiously Motivated Decisions on Medical Treatment » (1988), 93 *Dick. L. Rev.* 41, 65 ([Traduction] « L'essence même de la plupart des croyances religieuses est la relation entre une personne et un être suprême et la détermination de la valeur relative de la vie physique d'une personne sur terre et d'une éventuelle vie spirituelle dans l'au-delà »).

903. *Big M Drug Mart Ltd.*, précité, note 897, 337.

904. Voir *ibid.* Voir également Note, « Burdens on the Free Exercice of Religion: A Subjective Alternative » (1988-1989), 102 *Harv. L. Rev.* 1258, 1277.

905. Voir Alberta Attorney General, Office of the Chief Medical Examiner, *Protocol for Making Request for Donation of Tissue*, avril 1987.

906. Voir *Oakes*, précité, note 892, 136 et P.W. Hogg, *op. cit.*, note 893, p. 712.

Il faut toutefois se garder de conclure que, dans une société pluraliste et démocratique, la liberté de religion est absolue et ne souffre aucune restriction :

> La liberté au sens large comporte l'absence de coercition et de contrainte et le droit de manifester ses croyances et pratiques. La liberté signifie que, sous réserve des restrictions qui sont nécessaires pour préserver la sécurité, l'ordre, la santé ou les mœurs publics ou les libertés et droits fondamentaux d'autrui, nul ne peut être forcé d'agir contrairement à ses croyances ou à sa conscience[907].

Par exemple, une autopsie peut être justifiée, malgré les croyances religieuses du défunt ou de sa famille, lorsque la détermination des causes d'une mort inhabituelle s'avère impérieuse pour la société, que ce soit pour l'administration de la justice pénale ou pour la protection de la santé publique[908]. La responsabilité de l'État quant à la préservation de la vie et à la protection de la santé, surtout lorsqu'il s'agit de la santé de ceux qui sont incapables de se protéger eux-mêmes, a motivé des poursuites engagées contre des scientistes chrétiens qui n'avaient pas fourni à des mineurs à leur charge des traitements médicaux normaux et indispensables — poursuites ayant abouti à des condamnations[909]. Pour la même raison, des tribunaux ont reconnu à l'État le pouvoir de pratiquer des transfusions de sang sur des enfants, en dépit des objections religieuses des parents, lorsque leur vie était en jeu[910].

Essentiellement, donc, c'est la réalisation d'un équilibre dynamique qui est visée par la Charte dans le domaine de la liberté religieuse. Quand des intérêts collectifs de toute première importance sont en jeu et qu'il n'existe pas d'autres solutions, l'objectif et les moyens choisis par l'État peuvent nécessiter des atteintes plus ou moins graves à des convictions religieuses individuelles. Mais normalement, l'importance accordée par la société à la liberté religieuse, en tant que droit fondamental de la personne, suppose l'obligation de respecter les croyances personnelles et les actes dictés par la conscience. Dans des cas particulier, la mise en balance des valeurs en cause peut dépendre du degré et des effets de l'atteinte à la liberté de religion, ainsi que du poids de l'objectif poursuivi par l'État, des moyens qu'il entend prendre et de la prise en considération des convictions religieuses. Ainsi, dans la jurisprudence américaine portant sur la constitutionnalité des transplantations et des autopsies, on a attribué de l'importance à la mesure dans laquelle les dispositions législatives adoptées par un État briment l'exercice de la religion ou cherchent au contraire à le protéger. Dans le cas d'une femme estimant que ses croyances

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907. *R.* c. *Edwards Books and Art Ltd.*, [1986] 2 R.C.S. 713, 758, citant *Big M Drug Mart Ltd.*, précité, note 897.

908. Voir *Snyder* c. *Holy Cross Hospital*, 352 A. 2d 334 (Md. App. 1976). Voir cependant *Atkins*, précité, note 899 et *You Vang Yang*, précité, note 900. Après la décision *Snyder*, la loi du Maryland a été modifiée de manière à tenir davantage compte des objections d'ordre religieux. Voir William J. CURRAN, « Religious Objection to a Medicolegal Autopsy: Case and a Statute » (1977), 297:5 *N. Engl. J. Med.* 260. Comparer *Époux Camara*, *infra*, note 950.

909. Voir *R.* c. *Lewis* (1903), 7 C.C.C. 261 (C.A. Ont.) (la Cour a confirmé la condamnation pour homicide involontaire d'un adepte de la Science chrétienne ; il avait refusé de fournir les soins médicaux nécessaires à son fils, qui est mort de diphtérie). Voir également *Tutton*, précité, note 529.

910. *Re McTavish and Director, Child Welfare Act* (1986), 32 D.L.R. (4e) 394 (C.B.R. Alb.). Voir cependant *B (R.)* c. *Children's Aid Society of Metro Toronto* (1988), 47 D.L.R. (4e) 388 (C.A. Ont.).

religieuses avaient été violées parce que le médecin légiste avait prélevé les organes de son mari à la suite d'une autopsie, le tribunal a confirmé la validité de la loi en cause, jugeant que le législateur avait tenu compte des croyances religieuses en donnant aux familles l'occasion de s'opposer à l'avance à un tel prélèvement[911]. Plus récemment, un tribunal concluait qu'une loi sur les autopsies portait atteinte aux croyances religieuses, en partie parce qu'il existait des façons moins radicales de parvenir au but visé par le législateur[912].

D. Non-discrimination et égalité

Les dispositions de la Charte consacrées aux droits à l'égalité établissent une protection contre la discrimination de la part des pouvoirs publics, en posant l'égalité de tous pour ce qui concerne l'application de la loi :

> La loi ne fait acception de personne et s'applique également à tous, et tous on droit à la même protection et au même bénéfice de la loi, indépendamment de toute discrimination, notamment des discriminations fondées sur la race, l'origine nationale ou ethnique, la couleur, la religion, le sexe, l'âge ou les déficiences mentales ou physiques[913].

Celui qui se prétend victime de discrimination doit prouver qu'il fait l'objet d'un traitement inégal ou que la mesure prise par les autorités a des répercussions discriminatoires, au regard des types de discrimination énumérés ci-dessus ou d'un type analogue[914]. La Cour suprême du Canada s'est montrée disposée à favoriser une interprétation large de ces dispositions[915].

Les pouvoirs publics sont donc tenus d'agir d'une manière impartiale et d'éviter toute classification et toute action arbitraires ou abusives à l'égard de particuliers. Ainsi, les décisions de l'État concernant le financement de certaines transplantations pourraient être une source de discrimination, si elles sont arbitraires et irrationnelles au point d'être incompatibles avec le droit à l'égalité devant la loi[916]. Si les hôpitaux sont tenus de se conformer à la Charte ou aux dispositions législatives adoptées au chapitre des droits de la personne, les critères de sélection des patients inscrits sur les listes d'attente dressées

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911. *Fuller* c. *Marx*, 724 F. 2d 717 (8th Cir. 1984).

912. *You Vang Yang*, précité, note 900, 857.

913. Article 15.

914. Voir *Andrews* c. *Law Society of British Columbia*, [1989] 1 R.C.S. 143, 182. Voir également *R.* c. *Turpin*, [1989] 1 R.C.S. 1296, 1330-1335.

915. *Ibid.*

916. Voir *Brillo* c. *Schaller*, (13 juin 1986) Arizona 233587 (Sup. Ct) (le tribunal a ordonné à l'État de financer les transplantations du foie chez les adultes, après avoir conclu que le refus de le faire était irrationnel et portait atteinte au principe de l'égalité). Cet argument a également été soumis au cours d'un procès qui a contribué à persuader l'État du Vermont de modifier sa politique de non-financement des transplantations du foie chez les adultes. Le receveur potentiel concerné en l'espèce est mort avant de pouvoir profiter de la volte-face des autorités. Voir *Schmokel* c. *Secretary of State* (6 décembre 1988), Washington S-578-88 (Sup. Ct). Voir également Sally JOHNSON, « Vermont Case May Upset Transplant Policy », *New York Times* (15 janvier 1989) 34.

pour les transplantations doivent être conformes aux grands principes régissant les droits fondamentaux[917]. Ainsi, des critères qui fixent l'ordre de priorité en fonction de l'origine nationale ou ethnique, ou des critères « médicaux » ambigus qui, dans les faits, écartent certaines catégories de receveurs handicapés, ne résisteront à une contestation judiciaire que s'ils sont fondés sur des raisonnements inattaquables[918]. Le même principe s'applique sans doute à l'égard de l'éventuel recours à un critère de détermination de la mort particulier dans le cas des nouveau-nés anencéphales, dans la mesure où l'on se trouverait à exercer une discrimination abusive et démesurée contre eux en raison de leur état. Si, pour favoriser la préservation de la vie, l'État peut établir, en ce qui a trait au prélèvement d'organes, des principes qui soient mieux conciliables avec le droit de chacun à la vie et à la sécurité de sa personne, la Charte lui imposera probablement de donner préférence à ces principes.

Du reste, c'est peut-être dans cette optique qu'il y aurait lieu d'aborder toutes les mesures prises par les pouvoirs publics en matière de prélèvements et de transplantations, ainsi que les propositions faites en vue d'une réforme du droit applicable en la matière. Car dans le cas où une mesure porte atteinte aux droits à l'égalité, et une autre à la liberté de religion ou au droit de chacun à la sécurité de sa personne, la Charte paraît imposer à tous le respect d'au moins un principe, qui est le suivant. Lorsque, dans le cadre de la réforme du droit, il faut faire un choix entre plusieurs solutions, on devrait normalement retenir, du point de vue constitutionnel, celle qui répond à trois critères : (1) elle porte le moins atteinte aux droits fondamentaux de la personne ; (2) elle permettra vraisemblablement mieux d'assurer la protection de ces droits ; (3) sa mise en œuvre est fondée sur des moyens rationnels, clairement circonscrits, qui favorisent réellement la réalisation d'un objectif important et urgent.

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917. Par exemple, des mécanismes d'établissement de listes d'attente qui ne semblent pas être discriminatoires au regard des motifs énumérés à l'art. 15 ou de motifs analogues, pourraient tout de même s'opposer à la protection de la vie et au droit de chacun à la sécurité de sa personne prévus à l'art. 7, en privant certaines personnes de chances égales de vie, d'une manière incompatible avec les principes de justice fondamentale. Comparer *Stoffman*, précité, note 879 et *Turpin*, précité, note 914, 1334-1335. Voir également, *supra*, le texte accompagnant les notes 221 à 224.

918. Voir *Brillo*, précité, note 916 et Note, « Patient Selection for Artificial and Transplanted Organs » (1969), 82 *Harv. L. Rev.* 1322, 1338. Comparer, note 221, *supra*, et note 1001, *infra*.

CHAPITRE QUATRE

Droit comparé et droit international

Dans la mesure où l'on conclut à l'opportunité d'apporter des réformes à la législation canadienne sur le prélèvement de tissus humains, les solutions les plus intéressantes adoptées à l'étranger — ou les recommandations qui y ont été faites — pourraient servir de modèle ou tout au moins alimenter la réflexion. En étudiant les dispositions adoptées en Australie, en Grande-Bretagne, en France, en Belgique, aux États-Unis et par le Conseil de l'Europe en ce qui concerne le prélèvement d'organes sur des donneurs après leur mort, on constate que d'une manière générale, c'est l'une ou l'autre des trois solutions suivantes qui y a été retenue, avec des variantes : consentement exprès, présomption de consentement, demande obligatoire. Dans tous ces pays, les autorités ont eu du mal à définir le rôle juridique précis devant être joué par les membres de la famille. Des litiges ont parfois surgi au sujet de la protection des receveurs, ou sur des problèmes liés à la propriété de tissus déposés. On a partout veillé d'une façon particulière à réglementer les paiements associés au don de tissus et à interdire la vente d'organes. Dans une perspective plus large, nous pouvons nous inspirer de ces régimes pour tenter de décrire à grands traits l'évolution des règles applicables à propos des échanges de tissus à l'échelle internationale.

I. Grande-Bretagne : consentement exprès — « opting in »

Les lois sur l'anatomie, la cornée et les dons de tissus adoptées en Grande-Bretagne exercent depuis un siècle une influence énorme sur la législation canadienne[919]. En Grande-Bretagne, la loi subordonne le prélèvement d'organes sur des cadavres au consentement exprimé par le donneur avant son décès où à celui de la famille par la suite[920]. Cette solution favorisant le consentement exprès a été décrite par l'expression « opting in »[921]. En l'absence de la preuve que le défunt, ou sa famille, a expressément consenti au prélèvement, la société n'autorise pas le prélèvement de tissus humains ou d'organes sur le cadavre. La règle semble conforme aux traditions de la common law et du droit civil concernant les cadavres[922], mais on pourrait lui reprocher de ne pas prendre

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919. Voir *supra*, pp. 148-158.

920. *Human Tissue Act, 1961*, précité, note 829.

921. Voir M.A. SOMERVILLE, *loc. cit.*, note 847.

922. Voir *supra*, pp. 77-81.

en considération la nécessité de promouvoir, par le droit, l'objectif de la préservation de la vie ; car à moins d'un consentement exprès, la médecine se trouve à perdre des organes qui auraient pu servir à des transplantations.

Au cours des dernières années, du reste, le manque d'organes à l'échelle tant nationale qu'internationale a exercé une pression sur le système établi en Grande-Bretagne et a suscité des réformes législatives. Environ trois mille cinq cents personnes étaient inscrites sur les listes d'attente pour une greffe rénale en 1988[923]. Les raisons qui expliquent cette pénurie d'organes semblent être à peu près les mêmes qu'en Amérique du Nord, d'après certaines études : absence de diagnostic de mort cérébrale à l'égard de donneurs potentiels, réticences de la part des professionnels à demander le consentement au prélèvement d'organes, refus des donneurs potentiels ou des membres de la famille[924]. C'est pourquoi le ministère de la Santé a récemment obligé les autorités hospitalières à établir des directives écrites concernant le repérage des donneurs potentiels, l'établissement du diagnostic de mort cérébrale et la procédure concernant la demande de consentement adressée à la famille[925]. D'autres mesures sont également envisagée, notamment l'amélioration de la formation professionnelle ainsi que l'établissement de dispositions législatives suivant lesquelles des professionnels de la santé devraient, avec délicatesse, aborder la famille des patients qui viennent de mourir et sont considérés comme des donneurs potentiels, afin de lui offrir la possibilité de consentir au prélèvement d'organes au nom du défunt[926]. De telles dispositions ont été adoptées dans des pays où l'on a traditionnellement préféré la solution du consentement exprès, comme le Canada et les États-Unis : il s'agit de favoriser l'obtention d'un consentement lorsqu'un donneur potentiel est mort sans faire connaître ses volontés quant au prélèvement d'organes[927].

De récentes rumeurs concernant la participation de médecins britanniques à un commerce international d'organes ont alimenté le débat sur les diverses mesures envisageables pour augmenter le nombre de dons d'organes. Si la vente de cadavres humains pour les besoins de l'anatomie a été qualifiée de délit criminel au XVIII^e siècle, les textes britanniques adoptés au XIX^e et au XX^e siècles en matière de transplantations ont établi des régimes ne prévoyant aucune sanction pénale relativement à la vente d'organes[928]. Le législateur est intervenu en 1989, lorsque des allégations selon lesquelles des Turcs démunis avaient reçu de 2 000 à 3 000 £ pour le « don » d'un rein à des compatriotes sans le sou habitant à Londres[929] ont poussé le Parlement britannique à interdire explicitement

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923. John WARDEN, «Kidneys not for Sale» (1989), 298:6689 *Br. Med. J.* 1670.

924. Sheila M. GORE, Charles J. HINDS et Annabel J. RUTHERFORD, « Organ Donation from Intensive Care Units in England » (1989), 299:6709 *Br. Med. J.* 1193. Voir cependant A. BODENHAM, J.C. BERRIALGE et G.R. PARK, « Brain Stem Death and Organ Donation » (1989), 299:6706 *Br. Med. J.* 1009. Voir également Pamela E. BUCKLEY, « The Delicate Question of the Donor Family » (1989), 21:1 *Transplant. Proc.* 1411.

925. Circulaire 88(63) du ministère de la Santé (prélèvement d'organes en vue de transplantations). Voir également (février 1989), 47 *I.M.E. Bull.* 6.

926. J. WALLWORK, « Organs for Transplantation » (1989), 299:6711 *Br. Med. J.* 1291.

927. Voir *supra*, ch. III.

928. Voir *supra*, p. 127 et notes 808, 818 et 829.

929. Voir D. BRAHAMS, *loc. cit.* note 477 ; Richard BEESTON, « Mother Tells of Selling Kidney », *The [London] Times* (26 janvier 1989) 1. La loi turque pénalise la vente d'organes. Voir « Loi N° 2238 du 29 mai 1979 relative au prélèvement, au stockage, au transfert et à la greffe d'organes et de tissus » (T.C. *Resmî Gazete*, 3 juin 1979, N° 16655, pp. 1-4), reproduite dans (1980) 31:4 *R.I.L.S.* 1015.

la vente d'organes[930]. Le *Human Organ Transplants Act 1989* (loi de 1989 sur les transplantations d'organes humains) punit d'une amende maximale de 2 000 £ ou de trois mois d'emprisonnement (ou les deux) le fait d'offrir, de solliciter, d'acquérir ou de vendre un organe. La loi n'interdit pas le remboursement des frais engagés pour le prélèvement, le transport ou la conservation des organes, ni celui des frais directs ou de la perte de salaire raisonnables du donneur[931]. À cet égard, elle est semblable à la loi adoptée récemment au Manitoba pour interdire la vente de tissus humains[932]. En outre, elle restreint considérablement les transplantations entre des personnes qui ne sont pas liées du point du vue génétique, parce que les motifs auxquels répondent de telles interventions doivent faire l'objet d'un examen attentif. Cette loi interdit aussi la publicité relative à la vente d'organes, ce qui n'a pas été fait jusqu'ici au Canada[933].

II. France, Belgique et Conseil de l'Europe : présomption de consentement — « opting out »

Les législations française et belge sur le prélèvement d'organes sont à certains égards semblables à la législation britannique, mais elles en diffèrent sous d'autres aspects. Dans les trois cas, on a interdit la vente d'organes. Et en Belgique comme en France, on prohibe tout paiement autre que le remboursement des frais[934], ce qui s'accorde avec les textes britanniques et français établissant le caractère non lucratif des banques de lait humain et de sang[935]. En revanche, la Belgique, la France et beaucoup d'États de tradition civiliste[936] n'ont pas retenu, quant au prélèvement d'organes sur des personnes décédées, la solution du consentement exprès adoptée en Grande-Bretagne. La loi française, vieille d'une quinzaine d'années, et la loi belge, adoptée il y a quatre ans, sont toutes deux fondées sur la présomption de consentement, qu'elles permettent de mieux comprendre. Des mesures connexes prises en France traduisent par ailleurs les efforts de la société pour préciser et comprendre le statut moral et juridique du corps humain à notre époque.

A. France

Depuis 1976, les Français fondent sur la présomption de consentement le prélèvement d'organes sur des cadavres. La loi autorise la conservation, à des fins thérapeutiques et

930. *Human Organ Transplants Act 1989*, précité, note 526.

931. *Ibid.*

932. Voir LTHM, précitée, note 839, art. 15.

933. Voir *supra*, pp. 148-158.

934. Comparer : art. 3 de la *Loi n° 76-1181 du 22 décembre 1976*, J.O., 23 décembre 1976, p. 7365, reproduite dans (1977) 28:2 *R.I.L.S.* 341 et art. 4 de la *Loi du 13 juin 1986 sur le prélèvement et la transplantation d'organes* (Belgique) (1987), 38:3 *R.I.L.S.* 562 [ci-après *Loi du 13 juin 1986*].

935. Au sujet de la réglementation des banques de lait françaises, voir *Loi n° 89-899 du 18 décembre 1989*, J.C.P. 1990. III.15736 et *Arrêté du 15 juillet 1987*, J.O., 4 août 1987, p. 8769. Au sujet de la réglementation des banques de sang françaises, voir *Codes de la santé publique, de la famille et de l'aide sociale*, 8e éd., Paris, Dalloz, 1989, art. L-673 et L-674.

936. Voir M.A. Somerville, *loc. cit.*, note 847, 58. Voir en général A. Cantaluppi, A. Scalamogna et C. Ponticelli, « Legal Aspects of Organ Procurement in Different Countries » (1984), 16:1 *Transplant. Proc.* 102.

scientifiques, des organes et des tissus d'une personne après sa mort, sauf si, de son vivant, cette personne s'est opposée à un tel usage[937]. Ainsi, lorsqu'un médecin repère un donneur potentiel, il est tenu de consulter le registre de l'hôpital afin de s'assurer qu'aucune opposition n'a été inscrite[938].

En vigueur depuis plus de dix ans, la présomption de consentement ne semble pas avoir contribué beaucoup à atténuer la rareté des organes[939] :

> [TRADUCTION]
> Les résultats du régime de la présomption de consentement adopté en France se sont avérés décevants. Quoique le nombre d'organes disponibles ait un peu augmenté, la croissance de la demande a été de beaucoup supérieure à cette augmentation. En 1984, on a pratiqué près de 1 000 greffes rénales en France, mais près de 3 000 personnes étaient inscrites sur les listes d'attente[940].

Ces résultats sont peut-être attribuables à certaines tensions caractérisant la théorie de la présomption de consentement. Ils pourraient également tenir aux problèmes que pose l'application concrète de celle-ci.

La théorie de la présomption de consentement repose sur l'idée que la société peut raisonnablement présumer — en raison de la nécessité de sauver des vies et de l'altruisme de la collectivité — qu'une personne consent au prélèvement de ses organes après sa mort, sauf si elle s'y est opposée de son vivant. Autrement dit, « qui ne dit mot consent ». On estime que cette présomption permet à des patients d'obtenir une transplantation susceptible de leur sauver la vie, et qu'elle épargne aux familles des donneurs potentiels les tourments que peut occasionner une demande parfois présentée sans beaucoup de tact[941]. La présomption du consentement n'est pas absolue, cependant, car elle ne s'applique pas si l'opposition au prélèvement est établie. La preuve de cette opposition peut revêtir diverses formes : déclaration écrite, simple correspondance, comportement, déclarations verbales rapportées par un témoin. Se pose alors, sur le plan pratique, la question suivante : d'une manière générale, comment l'opposition au prélèvement devrait-elle être manifestée, comment la preuve devrait-elle en être obtenue ? Si l'on conclut que c'est principalement par l'établissement d'un registre qu'il faut permettre aux gens de faire connaître leur opposition au prélèvement (comme en France), le contenu de ce registre devrait-il être tenu pour péremptoire ?

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937. *Loi n° 76-1181*, précitée, note 934, art. 1.

938. Voir *Décret n° 78-501 du 31 mars 1978*, J.O., 4 avril 1978, p. 1497, art. 10, modifié par *Décret n° 90-844 du 24 septembre 1990*, J.O., 25 septembre 1990, p. 11606. Voir également *Circulaire du 3 avril 1978*, J.O., 5 avril 1978, p. 1530.

939. Voir ONT, *op. cit.*, note 29, p. 98.

940. Note, « Refining the Law of Organ Donation: Lessons from the French Law of Presumed Consent » (1987), 19 *N.Y.U. J. Int'l. L. & Pol.* 1013, 1024-1025.

941. CONSEIL D'ÉTAT, *Sciences de la vie : De l'éthique au droit*, 2e éd., Paris, La Documentation française, 1988, p. 36. Voir également Jesse DUKEMINIER et David SANDERS, « Organ Transplantation: A Proposal for Routine Salvaging of Cadaver Organs » (1968), 279:8 *N. Engl. J. Med.* 413, 416.

Les sociétés qui optent pour cette solution favorisent vraisemblablement l'efficacité, en limitant le nombre de sources que les professionnels de la santé doivent consulter avant de procéder au prélèvement. Mais on risque alors, dans certains cas, d'écarter des éléments de preuve qui permettraient de déduire d'une façon plus certaine et plus juste la volonté de l'intéressé. Les sociétés qui font preuve d'une plus grande prudence à l'égard de la présomption de consentement pourront tenir compte d'autres indications de cette volonté, surtout lorsqu'elles ne contredisent pas le contenu du registre. Les membres de la famille sont parfois en mesure de donner de telles indications, à cause des liens qui les unissaient au donneur potentiel, du fait qu'ils ont vécu avec lui. Aussi peut-on se poser cette question : si l'équipe médicale ne trouve aucune opposition au prélèvement dans le registre, devrait-elle consulter la famille afin de confirmer l'absence d'opposition de la part du défunt ?

La France a cherché à résoudre ces tensions en encourageant les professionnels de la santé à donner aux familles la possibilité de fournir des indications touchant la volonté du défunt :

> La loi veut qu'il soit tenu compte des seules volontés exprimées par la personne elle-même avant son décès, et non pas de celles de sa famille. La famille reste cependant, le plus souvent, le dépositaire privilégié des volontés exprimées par le défunt, soit que ce dernier en ait fait part verbalement à l'un ou plusieurs de ses parents, soit que ceux-ci détiennent des documents ou autres éléments de preuve du refus ou de l'acceptation du prélèvement. En outre, même si elle n'en est pas le dépositaire direct, la famille est souvent la mieux placée pour connaître ou découvrir ces justifications et les porter à la connaissance de l'établissement ou du médecin.
>
> Le rôle de la famille dans la transmission des volontés du défunt est particulièrement important si celui-ci, lors de son hospitalisation, était hors d'état de manifester sa volonté[942].

On ne peut pas savoir, à la lecture de ce texte, si l'équipe médicale est tenue de consulter la famille des patients qui n'avaient pas inscrit leur opposition dans le registre[943]. L'existence d'une telle obligation pourrait constituer une façon pratique de tenir compte des différents moyens de preuve qui semblent être envisagés dans la législation française sur la présomption de consentement[944]. La confirmation donnée par la famille favoriserait dès lors la certitude. En revanche, cette solution risque de battre en brèche l'objectif de la présomption, qui est de réduire le plus possible le rôle de la famille. Elle risquerait ainsi de nuire à l'efficacité du système.

En pratique, les équipes médicales françaises continuent à solliciter le consentement des familles des donneurs potentiels en état de mort cérébrale[945]. Cela peut s'expliquer par plusieurs raisons : coutume, tensions inhérentes à la théorie de la présomption de consentement, ambiguïtés correspondantes dans la loi et les règlements d'application,

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942. *Circulaire du 3 avril 1978*, précitée, note 938, p. 1532.

943. Voir *Décret n° 78-501 du 31 mars 1978*, précité, note 938, art. 10.

944. Voir *id.*, art. 8-10.

945. Conseil d'État, *op. cit.*, note 941, p. 39.

nécessité clinique et psychologique de faire preuve de délicatesse à l'endroit des familles éprouvées[946]. Dans les cas où l'on consulte la famille, la loi indique clairement les motifs pour lesquels elle peut s'opposer au prélèvement. Dans une affaire tranchée sept ans après l'adoption des dispositions relatives à la présomption de consentement, on a fermement établi que la loi n'accorde pas à la famille le droit de refuser le prélèvement en raison de ses propres objections[947]. Ainsi, les pratiques religieuses du défunt peuvent constituer un motif légal pour refuser le prélèvement, mais pas la répugnance d'un parent à l'égard des atteintes à l'intégrité corporelle qu'entraîne le recours à la haute technologie médicale.

Après une longue réflexion sur l'opportunité de maintenir la présomption de consentement, un comité gouvernemental a récemment proposé des modifications mineures à la législation française sur les transplantations d'organes, dans le cadre d'une proposition législative globale visant à définir le statut juridique et bioéthique du corps humain devant les changements rapides que connaît la science médicale[948]. La loi proposée réaffirme la présomption de consentement ainsi que la notion de don, et insiste sur le rôle des familles dans le prélèvement d'organes sur des personnes en état de mort cérébrale[949]. Alors même que s'élaborait cette proposition, la société française s'intéressait de plus en plus à la réglementation du développement, de la diffusion et des coûts de la technologie des transplantations.

On constate dont que si la proposition législative française se distingue par son caractère global, les choix qui s'offrent à la collectivité sont semblables à ceux auxquels doivent faire face les sociétés de l'Amérique du Nord. Les parents d'un enfant musulman, sur qui l'on avait pratiqué, après sa mort, des interventions médicales qui violaient des préceptes religieux de l'islam, ont récemment intenté une poursuite judiciaire qui a permis de préciser les limites de la présomption de consentement dans le cas des enfants mineurs[950]. Par ailleurs, l'innocuité des tissus humains est une préoccupation constante, comme le montrent les dommages-intérêts récemment accordés par un juge à la famille d'une personne morte de la rage, qu'elle avait contractée en raison d'une négligence dans l'examen des tissus cornéens implantés sur elle[951]. La définition de la mort a également suscité certaines

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946. Voir *ibid.*

947. Voir Cons. d'État, 18 mars 1983, *M^me^ Nguyen Ti Nam, épouse Trans Van Oanh*, J.C.P. 1983.II.20111 ; Ruth REDMOND-COOPER, « Transplants Opting Out or In — The Implications » (1984), 134 *New L.J.* 648.

948. Voir CONSEIL D'ÉTAT, *Avant-projet de loi sur les sciences de la vie et les droit de l'homme*, Paris, 1988. Voir également Jean Michel DUBERNARD et Jean-François MATTÉI « Bioéthique : l'urgence d'un débat au Parlement », *Le Monde* (18 avril 1990) 15. La loi proposée s'inspire d'un long rapport du gouvernement. Voir CONSEIL D'ÉTAT, *op. cit.*, note 941.

949. Voir *Décret n° 90-844 du 24 septembre 1990*, précité, note 938 ; *Décret n° 90-845 du 24 septembre 1990*, J.O., 25 septembre 1990, p. 11607, ainsi que six arrêtés concernant les listes d'attente, le nombre de centres de transplantation, etc. dans J.O., 25 septembre 1990, pp. 16607-16610.

950. Voir Conseil d'État, 17 février 1988, *Époux Camara*, J.C.P. 1990.II.21421 (décision : la loi française sur les transplantations subordonne les prélèvements en vue de transplantations au consentement exprès du tuteur du mineur décédé).

951. Cour d'appel de Paris, 19 juin 1989, *Zanne* c. *Banque française des Yeux/Hôpital Lariboisière* [inédit] ; Monique RAUX, « Un chercheur nancéien était mort de la rage après une greffe de la cornée », *Le Monde* (20 juin 1989) 34.

inquiétudes et certains conflits. Peu de temps après que l'Académie nationale de Médecine eut privilégié le terme de « mort cérébrale » pour définir la mort dans le contexte des transplantations[952], des accusations criminelles de voies de fait ont été portées dans le cas d'un patient âgé de vingt-quatre ans, déclaré en état de mort cérébrale et branché à un respirateur, sur lequel des expériences avaient été faites sans le consentement de la famille par un médecin d'un hôpital[953]. Alors que les commentateurs français débattent la question de savoir si une nouvelle loi relative à l'expérimentation sur des sujets humains s'applique aux patients se trouvant dans un tel état[954], le Comité consultatif national d'Éthique pour les Sciences de la Vie et de la Santé a recommandé de ne pas appliquer dans ce cas la présomption de consentement[955]. Le comité a également entrepris l'étude de certains problèmes ressortissant à la propriété et au droit de disposer des tissus[956], dans la foulée de certains litiges très particuliers, et troublants, intéressant des banques de tissus humains et des déposants[957].

B. Belgique

En 1986, la Belgique a adopté une loi fondée sur la présomption de consentement qui, malgré des similitudes avec le texte français, en diffère du point de vue de la portée et des effets[958]. D'abord, les données préliminaires recueillies indiquent que les prélèvements d'organes ont presque doublé depuis l'entrée en vigueur de la loi, ce qui ne correspond pas du tout avec ce qui s'est passé en France, comme nous l'avons vu[959].

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952. « L'Académie nationale de Médecine en France adopte un vœu à propos de la "mort cérébrale" » (1988), 39:3 *R.I.L.S.* 822 (rejet du terme traditionnel « coma dépassé », jugé ambigu).

953. Voir *supra*, ch. III, section II.C(3).

954. Comparer « L'expérimentation sur les comateux », *loc. cit.*, note 717 et Jean-Marie AUBY, « La Loi du 20 décembre 1988 relative à la protection des personnes qui se prêtent à des recherches biomédicales », J.C.P. 1989.I.3384, par. 14.

955. Voir *supra*, note 718.

956. COMITÉ CONSULTATIF NATIONAL D'ÉTHIQUE POUR LES SCIENCES DE LA VIE ET DE LA SANTÉ, « Avis sur les problèmes posés par le développement des méthodes d'utilisation de cellules humaines et de leurs dérivés », dans *Éthique et recherche biomédicale : Rapport 1987*, Paris, La Documentation française, 1988, pp. 18-21 (conclusions provisoires : (1) on peut présumer que les patients consentent, implicitement, à l'exploitation et à l'utilisation commerciales des cellules contenues dans des tissus malades ; (2) il est néanmoins préférable de les informer de la possibilité d'un tel usage ; (3) le patient dont proviennent des cellules cultivées et exploitées commercialement n'a aucun droit commercial sur le produit dérivé ; (4) la vente de lignées cellulaires par des chercheurs ne constitue pas une commercialisation du corps humain). Comparer *Moore* (1990), précité, note 426.

957. Comparer *Parpalaix*, précité, note 417. Jean-Yves NAU, « Engendrer après la mort », *Le Monde* (17 janvier 1990) 17 (cas d'une veuve ayant poursuivi une banque de sperme française pour se faire remettre du sperme congelé déposé par son mari alors qu'il était traité pour un cancer du testicule — le mari était mort du SIDA par la suite) et « Rejet d'une demande d'insémination post-mortem », *Le Monde* (27 mars 1991) 24.

958. *Loi du 13 juin 1986*, précitée, note 934 ; voir « Arrêté royal du 15 avril 1988 relatif aux banques de tissus et du prélèvement, de la conservation, de la préparation, de l'importation, du transport, de la distribution et de la délivrance des tissus » reproduit dans (1990) 41:1 *R.I.L.S.* 38.

959. Georges BINAMÉ, « Le prélèvement d'organes : chronique d'une loi annoncée » (1990), 41:2 *R.I.L.S.* 363, 365 ; L. RAELS et autres, « Effect of Presumed Consent Law on Organ Retrieval in Belgium » (1990), 22:4 *Transplant. Proc.* 2078.

Ces résultats positifs concordent plutôt avec l'impact de la présomption de consentement récemment établie aux États-Unis dans le cas des prélèvements de cornées[960].

Ensuite, la loi belge diffère de la loi française sous l'angle du champ d'application. Celle-ci précise que la présomption de consentement ne s'applique pas à l'égard des mineurs, des personnes atteintes de déficience mentale et des autres personnes jugées inaptes à manifester leur volonté[961]. La loi belge ne semble pas contenir de dispositions spécifiques à l'égard des déficients mentaux, mais la présomption de consentement est déclarée applicable aux mineurs[962]. La situation est donc la suivante : tandis qu'en France, le prélèvement d'organes sur le cadavre d'un mineur ne peut avoir lieu sans le consentement du tuteur, il peut en Belgique être effectué à moins que le tuteur s'y oppose. Enfin, le texte belge, à l'instar du texte français, permet à la famille du défunt de refuser de consentir au prélèvement, pourvu que ce refus ne s'oppose pas à la volonté exprimée par le donneur[963].

C. Conseil de l'Europe

On ne sera sans doute pas étonné, après cette description des législations belge et française, que la définition du rôle de la famille dans les prélèvements se soit avérée tout aussi délicate dans d'autres pays de l'Europe de l'Ouest dont plusieurs font partie du Conseil de l'Europe. Constitué après la Seconde Guerre mondiale en vue de promouvoir les droits de la personne[964], le Conseil de l'Europe a formulé des recommandations sur les transplantations d'organes ainsi que sur le transport et l'échange internationaux de tissus humains. Le Conseil a recommandé certains textes en vue d'harmoniser les législations et les politiques des vingt-deux États membres. On y trouve notamment exprimés les quatre grands principes suivants : (1) consentement exprès pour les prélèvements sur des personnes en vie ; (2) reconnaissance du critère de la mort cérébrale ; (3) présomption de consentement pour les prélèvements sur des cadavres ; (4) interdiction de toute contrepartie pécuniaire dans l'échange de tissus et d'organes, à l'exception du remboursement de la perte de revenu ou des frais occasionnés par le prélèvement, lorsque celui-ci est

960. Voir, *infra*, le texte accompagnant la note 1008.

961. Voir *Époux Camara*, précité, note 950. Voir également CONSEIL D'ÉTAT, *op. cit.*, note 941, p. 36.

962. Voir art. 10.2 de la *Loi du 13 juin 1986*, précitée, note 934. Une telle présomption pourrait donner lieu à un litige fondé sur la Charte au Canada.

963. Voir *id.*, art. 10. Les règles établissant une quasi-présomption de consentement, suivant lesquelles le défunt ou sa famille ont le droit de manifester une opposition en toute connaissance de cause, ont été qualifiées de règles autorisant les « prélèvements de routine ». Voir Arthur J. MATAS, John ARRAS, James MUYSKENS, Vivian TELLIS et Frank J. VETTH, « A Proposal for Cadaver Organ Procurement: Routine Removal With Right of Informed Refusal » (1985), 10 *J. Health Pol. Pol'y L.* 231.

964. Voir *Convention de sauvegarde des droits de l'homme et des libertés fondamentales*, 4 novembre 1950 (1955), 213 *R.T.N.U.* 233 (entrée en vigueur le 3 septembre 1953). Les pays signataires sont l'Allemagne de l'Ouest, l'Autriche, la Belgique, Chypre, le Danemark, l'Espagne, la France, la Grèce, l'Irlande, l'Islande, l'Italie, le Liechtenstein, le Luxembourg, Malte, la Norvège, le Portugal, les Pays-Bas, le Royaume-Uni, Saint-Marin, la Suède, la Suisse et la Turquie.

pratiqué sur une personne vivante[965]. Le Conseil a également proposé une entente sur l'échange et le transport internationaux des substances thérapeutiques d'origine humaine, afin de faciliter les échanges entre les États membres[966].

En tant que tribune européenne des droits de la personne, le Conseil a déclaré qu'il y avait lieu de faciliter les prélèvements d'organes en Europe, tout en respectant les « droits et libertés individuels »[967]. Soulignons à cet égard que treize des vingt-deux États membres ont emprunté la voie de la présomption de consentement, en ce qui a trait au prélèvement d'organes sur les cadavres[968]. Cette présomption est fondée sur la pénurie d'organes, le nombre de vies susceptibles d'être sauvées grâce à une augmentation de l'offre, ainsi que l'opinion selon laquelle le cadavre n'a pas de droits, hormis le droit au respect[969] :

> Aussi, lorsque le droit à la vie et à la santé du malade attendant une transplantation entre en conflit avec le « droit » supposé d'un cadavre qui n'est plus une personne, le droit du receveur vivant l'emporte certainement sur celui du donneur décédé. L'intérêt de la communauté prévaut sur celui du corps mort[970].

En reconnaissant ainsi la prépondérance du droit à la vie, ne fait-on pas preuve d'indifférence à l'égard des sentiments de la famille ? En vertu des dispositions sur la présomption de consentement en vigueur en Autriche et au Luxembourg, par exemple, le point de vue de la famille ou des proches n'est pas pris en compte[971]. L'analyse du Conseil a toutefois révélé qu'en pratique, beaucoup d'États membres hésitent à appliquer d'une façon rigoureuse cette présomption[972] — ce qui donne à penser que l'attitude adoptée en Belgique et en France reflète sans doute la politique suivie en général par les États membres du Conseil de l'Europe : « [La] pratique dans la plupart des États montre que l'on consulte la famille et, quoique dans la plupart des cas son opinion ne l'emporte pas en droit, personne n'oserait aller à l'encontre du refus exprimé par la famille[973] ». Le Conseil a recommandé qu'on étudie plus à fond le rôle de la famille dans la décision finale concernant le prélèvement d'organes sur le défunt[974]. Il reste à savoir si une telle

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965. Conseil de l'Europe, « 3e Conférence des Ministres européens de la Santé (Paris, 16-17 novembre 1987) » (Texte final sur la transplantation d'organes) (1988), 39:1 *R.I.L.S.* 294. [ci-après Texte final] et *infra*, note 971. Voir également Conseil de l'Europe, « Résolution (78) 29 sur l'harmonisation des législations des États membres relatives aux prélèvements, greffes et transplantations de substances d'origine humaine » (1978), 29:4 *R.I.L.S.* 1172.

966. Conseil de l'Europe, « Recommandation N° R (79) du Comité des Ministres aux États membres concernant le transport et l'échange internationaux de substances d'origine humaine » (1979), 30:4 *R.I.L.S.* 1071.

967. Voir Texte final, *loc. cit.*, note 965, 295.

968. Voir Conseil de l'Europe, Conférence des Ministres européens de la Santé, *La transplantation d'organes — Troisième rapport : Mesures législatives relatives à la transplantation d'organes et à la coopération européenne*, Strasbourg, le Conseil, 1987, p. 7.

969. *Ibid.*

970. *Ibid.*

971. Conseil de l'Europe, Conférence des Ministres européens de la Santé, *Organ Transplantation: Current Legislation in Council of Europe Member States and Finland and Results of European Co-operation*, Strasbourg, le Conseil, 1987, pp. 27, 29.

972. Conseil de l'Europe, *op. cit.*, note 968, p. 7.

973. Conseil de l'Europe, *op. cit.*, note 971, p. 26.

974. Conseil de l'Europe, *op. cit.*, note 968, p. 9.

étude amènera des changements qui feront augmenter le nombre d'organes prélevés en Europe. Pour l'instant, les listes d'attente continuent de s'allonger, tout comme en Amérique du Nord[975].

III. États-Unis : demande obligatoire et mécanismes de sensibilisation

Ces dernières années, un consensus s'est dégagé aux États-Unis, tant dans la législation que dans la politique officielle, en matière de prélèvement de tissus et d'organes. On s'accorde en effet pour dire que la pénurie d'organes est criante, que la vente d'organes est inacceptable et devrait être interdite, et que les remèdes envisagés face à la pénurie devraient être à la fois pratiques et fondés sur l'encouragement à l'altruisme. Ce consensus s'est exprimé par une vague de textes législatifs qui a balayé les États-Unis au cours des cinq dernières années.

Un auteur a décrit dans les termes suivants l'approche législative retenue aux États-Unis :

> [TRADUCTION]
> Les lois favorisent le repérage des donneurs potentiels et exigent qu'on demande à la famille de consentir au prélèvement des organes du patient qui est mourant ou est déjà mort, ou qu'on l'informe des possibilités de dons d'organes. [. . .] [U]ne politique de sensibilisation systématique n'oblige personne à demander un consentement contre son gré, et elle n'exige pas non plus qu'une demande soit faite à la famille. Elle consiste simplement à obliger les hôpitaux à mettre sur pied des mécanismes propres à garantir que la famille se voie offrir la possibilité de consentir au prélèvement[976].

Plus de quarante-quatre États américains ont adopté des lois de ce genre depuis l'adoption des premières en Oregon, en Californie et dans l'État de New York en 1985[977]. Comme l'indique la citation ci-dessus, le législateur a habituellement retenu soit la « demande obligatoire », soit l'établissement de « mécanismes de sensibilisation ». La seconde solution est considérée comme la plus douce. Elle consiste à forcer les hôpitaux à mettre sur pied des mécanismes propres à garantir que la famille du donneur potentiel n'ayant pas exprimé sa volonté soit informée de la possibilité du don d'organes[978]. Les

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975. Voir B. COHEN, « Rapid Changes in the Work of an International Exchange Organization: Eurotransplant » (1988), 20:5 *Transplant. Proc.* 817, 818 et Conseil de l'Europe (novembre 1990), 2 *Transplant* 161. Voir également Jeffrey PROTTAS, « Organ Procurement in Europe and the United States » (1985), 63 *Milbank Mem. Fund. Q.* 94.

976. Daphne SIPES, « Requesting Organ Donations: A New State Approach to Organ Transplant » (1987), 8:2 *Health L. Can.* 39, 40.

977. Kathleen S. ANDERSEN et Daniel M. FOX, « The Impact of Routine Inquiry Laws and Organ Donation » (1988), 7 *Health Aff.* 65.

978. AMERICAN HOSPITAL ASSOCIATION, AMERICAN MEDICAL ASSOCIATION et UNITED NETWORK FOR ORGAN SHARING, *Required Request Legislation: A Guide for Hospitals on Organ & Tissue Donation*, AHA, AMA, UNOS, 1988, p. 1.

textes axés sur la « demande obligatoire » sont quant à eux rédigés en termes plus impératifs. Ils forcent les hôpitaux à prendre les moyens nécessaires pour que la famille se voie demander dans tous les cas si elle consent au prélèvement[979].

Pourquoi cette solution a-t-elle été retenue par l'immense majorité des États américains ? Ce fait témoigne d'un consensus sur les causes principales de la pénurie d'organes et de tissus humains, et sur les méthodes à privilégier pour y remédier. Le moyen adopté — soit l'obligation légale d'offrir à la famille la possibilité de consentir au prélèvement — est centré sur l'un des aspects les plus délicats et les plus pénibles, du point de vue psychologique, du processus de don d'organes : le moment où il faut s'adresser à la famille d'une personne qui vient de mourir et qui est considérée comme un donneur potentiel. Il vise à résoudre un problème reconnu. Des études et des rapports réalisés aux États-Unis comme au Canada font en effet état de la forte réticence des professionnels de la santé à aborder la famille dans de telles situations[980]. Des groupes de travail canadiens, tant fédéraux que provinciaux, ont conclu que cette réticence est un obstacle majeur à l'augmentation des prélèvements[981]. Ce point de vue est partagé par des spécialistes américains. En 1985, un rapport spécial du Hastings Center concluait que l'un des principaux freins au don d'organes résidait dans le refus de demander le consentement de la famille, de reconnaître le rôle clé joué par les proches parents[982]. Le rapport recommandait l'adoption de lois portant sur la demande obligatoire ou l'établissement de mécanismes de sensibilisation[983]. Les conclusions du Hastings Center et des rapports canadiens ont été renforcées deux ans plus tard par un groupe de travail américain sur les transplantations d'organes :

> [TRADUCTION]
>
> *Le groupe de travail conclut que le principal problème du système actuel fondé sur le don volontaire d'organes tient à ce que souvent, les familles ne sont pas informées de la possibilité d'un tel don après la constatation de la mort cérébrale.* Comme beaucoup de familles ne sont pas au courant, on pourrait vraisemblablement prélever plus d'organes, dans le respect du principe juridique du consentement volontaire, si elles étaient systématiquement informées de la possibilité du don d'organes et de tissus lors de la mort d'un parent. [...]
>
> *Le groupe de travail recommande que tous les professionnels de la santé participant aux soins donnés à des donneurs potentiels d'organes et de tissus acceptent volontairement la responsabilité de désigner* ces donneurs et de les confier aux organismes de prélèvement d'organes appropriés. [...]
>
> Le groupe de travail *recommande que les hôpitaux adoptent des lignes de conduite et des mécanismes du type « demande obligatoire » ou « sensibilisation systématique » permettant de repérer les donneurs potentiels et d'offrir à la famille des possibilités adéquates quant au don d'organes.* [...]

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979. *Ibid.*

980. Voir, *supra*, le texte accompagnant les notes 228-233.

981. *Ibid.*

982. THE HASTINGS CENTER, *Ethical, Legal and Policy Issues Pertaining to Solid Organ Procurement*, Hastings-on-Hudson (N.Y.), The Hastings Center, 1985, p. 15.

983. *Id.*, pp. 21-22.

> Même si l'on utilise souvent l'expression « demande obligatoire », une politique de sensibilisation systématique n'oblige personne à demander un consentement contre son gré, et elle n'exige pas non plus qu'une *demande* soit faite à la famille. Elle consiste simplement à obliger les hôpitaux à mettre sur pied des mécanismes propres à garantir que la famille se voie *offrir* la possibilité de consentir au prélèvement. La distinction est importante parce que les personnes réagissent plus positivement lorsqu'on leur offre un choix[984].

À l'appui de sa recommandation, le groupe de travail faisait valoir que, dans la plupart des cas, la famille du donneur potentiel ne s'oppose pas à ce qu'on lui parle de la possibilité du don d'organes ; elle considère même parfois que cela s'inscrit dans le processus du deuil[985].

La faveur dont jouissent aux États-unis les solutions axées sur la demande obligatoire et sur les mécanismes de sensibilisation tient aussi au fait qu'elles sont les plus satisfaisantes sur le plan des principes. Par rapport à la vente d'organes (libre ou réglementée)[986] et à la présomption de consentement, elles sont jugées plus respectueuses de l'altruisme, des sentiments de la famille et des convictions religieuses[987]. Si, d'une façon générale, ces solutions rendent obligatoire une démarche auprès de la famille, celle-ci conserve le droit de rejeter la possibilité d'un don d'organes[988]. Elles reposent sur l'idée que la difficulté ne consiste pas à susciter l'altruisme, mais à aider les gens à concrétiser leurs bonnes intentions[989].

La nouveauté de cette législation empêche l'appréciation de son efficacité. En effet, les données ayant trait à ses effets sur le prélèvement d'organes demeurent peu concluantes. D'une part, certains médecins ont reproché à ces dispositions de porter atteinte à l'indispensable discrétion professionnelle, ainsi qu'à l'autonomie et à la vie privée des familles, et de constituer une étape vers l'adoption de mesures plus coercitives[990]. D'autre part, on a enregistré des progrès au chapitre du nombre des prélèvements : hausse de 135 %

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984. USTF, *op. cit.*, note 29, pp. 31, 33, 32 [mis en italiques par nos soins].

985. *Id.*, p. 32 ([TRADUCTION] « Le don d'organes et de tissus est presque toujours une source profonde de consolation pour les familles des patients qui meurent d'une manière inattendue et prématurée »). Voir également H. LEVINE BATTEN et J.M. PROTTAS, *loc. cit.*, note 227, 38 (ce qui motivait 86 % des familles ayant consenti à des prélèvements qui ont été interrogées, c'était la volonté de [TRADUCTION] « voir quelque chose de positif être tiré de la mort »).

986. Voir en général Note, « Regulating the Sale of Human Organs » (1985), 71 *Va L. Rev.* 1015.

987. Voir Arthur L. CAPLAN, « Ethical and Policy Issues in the Procurement of Cadaver Organs for Transplantation » (1984), 311:15 *N. Engl. J. Med.* 981, 982.

988. Voir *ibid.*

989. Voir Jeffrey M. PROTTAS, « Encouraging Altruism: Public Attitudes and the Marketing of Organ Donation » (1983), 61 *Milbank Mem. Fund Q.* 278, 279.

990. Voir, par exemple, Susan MARTYN, Richard WRIGHT et Leo CLARK, « Required Request for Organ Donation: Moral, Clinical, and Legal Problems » (1988), 18:2 *Hast. Cent. Rep.* 27. Voir cependant A.L. CAPLAN, « Professional Arrogance and Public Misunderstanding » (1988), 18:2 *Hast. Cent. Rep.* 34.

pour les banques d'yeux de l'Oregon[991], de 180 % pour une banque de peau de l'État de New York[992] ; le phénomène a aussi été constaté en Californie[993] et au Michigan[994].

Si, au départ, c'est dans un petit nombre d'États que s'est concrétisée l'idée de dispositions sur la demande obligatoire, des modifications à la législation « uniforme » et à la loi fédérale ont encouragé les autres États à en adopter de semblables. Le *National Organ Transplantation Act* (NOTA) de 1984[995] a été adopté par le Congrès des États-Unis en vue de faciliter et d'améliorer les prélèvements d'organes et leur attribution à l'échelle nationale. Par ce texte, le législateur accomplissait diverses choses : (1) formation d'un groupe de travail national chargé d'étudier la question du prélèvement et de la transplantation d'organes ; (2) constitution d'un registre national informatisé permettant l'échange de données sur les prélèvements d'organes ; (3) aide relative aux activités régionales liées au prélèvement d'organes ; (4) mise sur pied d'un registre national de donneurs de moelle osseuse[996] ; (5) interdiction, sous peine d'une amende de 50 000 $ ou de cinq ans de prison (ou les deux), du transfert (fait sciemment) entre États et à titre onéreux, d'un organe (rein, foie, cœur, poumon, pancréas, moelle osseuse, cornée, œil, os ou peau, le sang étant toutefois exclu) ; (6) obligation des hôpitaux subventionnés par l'administration fédérale d'adopter des lignes de conduite écrites visant le repérage des donneurs d'organes potentiels (suivant les recommandations du groupe de travail américain)[997].

Plusieurs autres aspects de la loi méritent d'être mentionnés. Premièrement, l'interdiction de la vente d'« organes » humains et la définition donnée à ce terme ne visent pas, d'une manière générale, les tissus susceptibles de régénération, et dont le prélèvement

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991. Voir Terry E. BURRIS et autres, « Impact of Routine Inquiry Legislation in Oregon on Eye Donations » (1987), 6:3 *The Cornea* 226.

992. Voir NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, *Transplantation in New York State: The Procurement and Distribution of Organs and Tissues*, New York, The Task Force, 1988, p. 155.

993. Voir K.S. ANDERSEN et D.M. FOX, *loc. cit.*, note 977, 76-77.

994. Voir Beverly MERZ, « The Organ Procurement Problem: Many Causes, No Easy Solutions » (1985), 254:23 *JAMA* 3285, 3287. Voir cependant Arthur L. CAPLAN et Beth VIRNING, « Is Altruism Enough? Required Request and the Donation of Cadaver Organs and Tissues in the United States » (1990), 6:4 *Critical Care Clinics* 1007, 1011.

995. Pub. L. No. 98-507, 98 Stat. 2339, codifiée à 42 U.S.C. art. 273, 274, 1320b-8 [ci-après NOTA].

996. On semble près d'atteindre l'objectif fixé (100 000 donneurs inscrits au registre), mais cela risque fort de ne pas répondre aux besoins existant aux États-Unis. Voir « Programs to Find Marrow Donors in Falling Short », *New York Times* (11 décembre 1989) A18. Voir également « Transplant Reward Offer Raises Furor », *New York Times* (23 juin 1989) A6 (Offre de 5 000 $ dans le but d'attirer un donneur de moelle osseuse compatible) ; « Girl Born to Couple Who Seek Marrow Donor », *New York Times* (7 avril 1990) 8 (cas d'un couple ayant conçu un enfant en vue de prélever sur lui de la moelle osseuse pour la greffer à sa sœur adolescente qui se mourait de leucémie). Voir également *Transplant Amendments Act of 1990*, Pub. L. No. 101-616, 104 Stat. 3279 (figurera à 42 U.S.C.S. art. 301); ces modifications visent à l'enrichissement du registre de donneurs de moelle osseuse.

997. Voir 53 *Fed. Reg.* 6526, 6527, 6544 (1er mars 1988) (figure à 42 C.F.R.)

ne comporte aucun risque physique pour le donneur[998]. De récentes modifications à la loi précisent que l'interdiction de vente s'applique aux organes fœtaux et aux parties (« subparts ») d'organes[999]. Deuxièmement, l'interdiction de la « vente » ne vise pas le versement d'une somme pour les frais ayant trait au prélèvement, au traitement, à la conservation et au transport des organes, ni aux frais supportés par le donneur (déplacement, hébergement, perte de salaire — ce qui s'accorde avec les récentes dispositions adoptées en Grande-Bretagne et au Manitoba, ainsi qu'à la recommandation du Conseil de l'Europe[1000]. Troisièmement, la législation américaine connexe a apparemment conféré aux États toute latitude pour financer ou non les transplantations, et ces décisions d'ordre financier ont donné lieu à des litiges[1001].

Enfin, un réseau national de prélèvement et de transplantation d'organes a été constitué en vertu des règlements d'application de la NOTA. Ce réseau regroupe quelque soixante-dix agences accréditées de prélèvement d'organes dans onze régions désignées du territoire des États-Unis. Le système national de prélèvement d'organes est géré par le United Network for Organ Sharing (UNOS), un organisme privé lié contractuellement au Department of Health and Human Services, qui surveille son fonctionnement[1002]. Sous les auspices de ce dernier, le UNOS élabore des lignes de conduite nationales, à la lumière des commentaires reçus du public et en s'appuyant sur la réflexion de divers comités nationaux. Par exemple, les délibérations du comité des relations étrangères de l'UNOS ont contribué à la conception de la politique américaine en matière d'échanges internationaux d'organes, par le truchement des principes dégagés par l'UNOS, qui, d'une manière générale : (1) interdisent l'exportation, à l'extérieur de l'Amérique du Nord, d'organes

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998. Voir *U.S. Code Cong. & Ad. News*, précité, note 481, 3982 (« Le comité est d'avis qu'aucun particulier et aucun organisme ne devrait tirer profit de la vente d'organes humains destinés à des transplantations. Ne sont visés ni le sang ni les dérivés du sang, qui sont susceptibles de régénération et dont le prélèvement ne compromet pas la santé du donneur. »). La distinction est d'autant plus logique que la nature des greffes de moelle osseuse ou de peau, et les risques qu'elles comportent, rapprochent davantage ces interventions des transplantations d'organes vitaux que du don de sang ou de sperme. D'où leur inclusion dans la définition du terme « organe », pour l'application des dispositions interdisant la vente. Soulignons en outre que si les dispositions fédérales interdisant la vente d'organes s'appliquent aux tissus prélevés sur des « donneurs » vivants et morts, l'interdiction prévue dans la loi « uniforme » ne s'applique qu'aux tissus prélevés sur des cadavres. Comparer NOTA, précité, note 995, art. 274e et UAGA, *infra*, note 1004, art. 10.

999. *Organ Transplant Amendments Act of 1988*, Pub. L. No. 100-607, art. 407, 102 Stat. 3114 (1988) (modifiant 42 U.S.C.S. 274(*e*)(c)(1)).

1000. Voir 42 U.S.C.S., al. 274*e*).

1001. Comparer *Ellis* c. *Patterson*, 859 F. 2d 52 (8th Cir. 1988) (le tribunal a conclu que les modifications de 1986 au régime de l'assurance maladie des É.-U., 42 U.S.C., al. 1396*b*(i), confèrent aux États toute latitude pour subventionner, ne pas subventionner ou subventionner partiellement les transplantations d'organes, et exigent que les plafonds ne soient ni arbitraires ni déraisonnables) ; *Todd* c. *Sorrell*, 841 F. 2d 87 (4th Cir. 1988) (obligation pour l'État de payer les frais d'un patient ayant subi une transplantation du foie) ; *Montoya* c. *Johnston*, 654 F. Supp. 511 (W.D. Tex. 1987) (le plafond fixé à 50 000 $ quant au remboursement par l'État des frais hospitaliers privait d'une façon abusive et déraisonnable de la protection du régime public un enfant dont l'état nécessitait une transplantation du foie coûtant entre 100 000 $ et 200 000 $). Pour une étude sur les raisons motivant le remboursement des transplantations du foie aux États-Unis, voir 56 *Fed. Reg.* 15,006 (12 avril 1991). Les assureurs privés non plus ne sont pas à l'abri de poursuites dans ce domaine. Voir *Dozsa c. Crum & Forster Insurance Co.*, 716 F. Supp. 131 (D. N.J. 1989) (compagnie d'assurance se faisant ordonner de rembourser les frais entraînés par des transplantations de moelle osseuse).

1002. Voir John C. McDonald, « The National Organ Procurement and Transplantation Network » (1988), 259:5 *JAMA* 725.

prélevés aux États-Unis, sauf s'il est impossible de trouver un receveur américain ; (2) autorisent les centres de transplantations américains à conclure des protocoles formels d'échange d'organes avec des centres étrangers de transplantation reconnus par l'UNOS ; (3) interdisent l'importation *ad hoc* d'organes, sauf si elle est coordonnée ou approuvée par l'UNOS ; (4) soumettent à des vérifications les centres où plus de 10 % des transplantations annuelles sont pratiquées sur des étrangers non résidants[1003].

Des dispositions législatives semblables à celles de la NOTA ont été adoptées à l'occasion de récentes modifications apportées à la loi type sur les dons anatomiques. En 1987, la loi type sur les dons de tissus humains, vieille de vingt ans, a été modifiée[1004]. La nouvelle « loi uniforme », axée sur les mécanismes de sensibilisation[1005], comporte aussi une quasi-présomption de consentement. Elle donne au coroner ou au médecin légiste le pouvoir d'autoriser tous prélèvements sur un cadavre dont il a légalement la garde, pourvu que des efforts raisonnables, compte tenu de la vie utile des organes en cause, aient été faits pour contacter les parents du défunt[1006]. Cette condition devrait permettre d'éviter les contestations civiles et constitutionnelles instituées dans certaines États américains à l'égard de textes et de pratiques fondées sur la présomption de consentement, en ce qui a trait au prélèvement des tissus oculaires[1007]. La disposition de la loi type élargit considérablement le champ d'application de cette présomption de consentement, qu'elle rend applicable aux autres prélèvements. On estimait en effet que de telles dispositions répondent aux intérêts légitimes de l'État à l'égard de la protection de la santé et de la préservation de la vie, et l'on se fondait sur des données indiquant qu'elles faisaient augmenter le nombre de transplantations (en Floride, par exemple, les greffes de la cornée

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1003. Voir *UNOS Policy on Transplantation of Foreign Nationals* (6.0-6.6) (en vigueur en juillet 1991). Voir également *UNOS Policies: Changes as of December 6, 1988* (3.14) (l'entente temporaire de partage des organes entre les É.-U. et le Canada est expirée). Pour des précisions sur les dispositions qui restreignent l'accès de patients étrangers aux listes d'attente américaines, voir USTF, *op. cit.*, note 29, pp. 93-95. Voir également « Medicare Program; Payment for Kidneys Sent to Foreign Countries or Transplanted in Patients Other than Medicare Beneficiaries », 42 C.F.R., art. 413.179.

1004. Voir *Uniform Anatomical Gift Act (1987)*, 8A U.L.A. (1990 Supp.) [ci-après UAGA], discuté dans A. McIntosh, « Regulating the "Gift of Life" — The 1987 Uniform Anatomical Gift Act » (1990), 65:1 *Wash. L. Rev.* 171. Voir également *Uniform Determination of Death Act* (1980), 12 U.L.A. 320 (1990 Supp.) (adopté dans la plupart des États).

1005. UAGA, précité, note 1004, art. 5.

1006. *Id.*, art. 4.

1007. Certains États, notamment la Floride, le Michigan, le Texas, le Tennessee et le Kentucky, se sont inspirés de la loi adoptée au Maryland en 1975, en autorisant le prélèvement de tissus oculaires lorsque les conditions suivantes sont réunies : (1) un cadavre a été confié au coroner en vue d'une autopsie ; (2) il n'y a aucune « objection connue » au prélèvement des tissus cornéens ; (3) le prélèvement n'occasionnera aucun défigurement ni aucune mutilation du corps et ne nuira pas à l'autopsie. Voir *Md Est. & Trusts Code Ann.*, art. 4-509.1 (1989 Supp.). Des actions ont été intentées au sujet de prélèvements effectués en l'absence de quelque « objection connue » sans qu'on ait véritablement donné à la famille du défunt l'occasion de s'y opposer. Voir *Brotherton*, précité, note 894 ; *Kirker*, précité, note 403; *Powell*, précité, note 895 ; *Georgia Lions Eye Bank*, précité, note 894 ; *Tillman*, précité, note 894. Comparer l'obligation de tenter de « bonne foi » de contacter la famille, prévue dans la loi du Massachusetts sur le prélèvement des tissus oculaires, *Mass. Gen. Laws Ann.*, ch. 113, art. 14 (1989 Supp.), et les récentes modifications législatives apportées au Rhode Island — R.I. Gen Laws, ch. 4, art. 23-4-4.1 (Michie 1990 Supp.) — celles-ci ont été suscitées par l'affaire *You Vang Yang*, précitée, note 900.

étaient passées de 500 à 3 000)[1008]. Ce nouveau texte a jusqu'ici été adopté par un certain nombres d'États américains[1009].

IV. Australie : présomption de consentement, sous réserve de l'opposition de la famille

C'est par suite de recommandations de la Commission de réforme du droit de l'Australie (CRDA)[1010] que la plupart des hôpitaux du pays appliquent les mêmes règles à l'égard des donneurs potentiels ayant autorisé les prélèvements sur leur cadavre et de ceux qui ne l'ont pas fait. La CRDA a recommandé, premièrement, que les hôpitaux soient autorisés à prélever les tissus et les organes des donneurs ayant donné un consentement explicite, malgré les éventuelles objections des membres de la famille[1011]. Cette recommandation est fondée sur les principes éthiques de l'autonomie et de la bienfaisance : il s'agit de respecter les volontés du défunt tout en répondant aux besoins médicaux des receveurs[1012]. Deuxièmement, la commission a recommandé que les hôpitaux soient autorisés à faire des prélèvements sur les donneurs potentiels n'ayant pas exprimé leur volonté, à condition de procéder tout d'abord à des vérifications raisonnables :

> [TRADUCTION]
> Lorsqu'une personne meurt dans un hôpital ou que son corps y est amené, l'hôpital lui-même, par l'entremise d'un agent désigné, devrait avoir le pouvoir d'autoriser des prélèvements en vue de transplantations ou pour les autres motifs énoncés ci-dessus, après avoir tout d'abord vérifié si le défunt a exprimé un consentement ou une objection ou, lorsqu'il ne l'a pas fait ou qu'il est impossible de le savoir, s'il existe des objections de la part des membres de la famille. Tout consentement ou opposition exprimé par le défunt sera déterminant. L'obligation de l'hôpital devrait être d'effectuer « les vérifications raisonnables dans les circonstances »[1013].

La proposition de la CRDA semblerait constituer un moyen terme, pour les cas où le donneur potentiel n'a pas exprimé ses volontés, entre la solution retenue aux États-Unis (demande obligatoire, mécanismes de sensibilisation) et la présomption de consentement établie dans les pays de l'Europe de l'Ouest. Elle se rapproche en gros de la solution américaine, dans la mesure où l'on est tenu de tenter de consulter la famille avant de procéder au prélèvement, et d'agir conformément à sa volonté. Mais elle s'en écarte aussi, puisque le consentement est présumé dans le cas où il n'est pas raisonnablement possible de communiquer avec les proches parents — ce qui correspond à un point de vue minoritaire

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1008. Voir UAGA, précité, note 1004, art. 4, commentaires.

1009. Voir UAGA, précité, note 1004.

1010. COMMISSION DE RÉFORME DU DROIT DE L'AUSTRALIE, *Human Tissue Transplants*, Rapport n° 7, Brisbane, Watson Ferguson and Co., 1977 [ci-après CRDA].

1011. *Id.*, par. 144, pp. 65-66.

1012. *Id.*, par. 140, p. 64. Voir également *supra*, ch. III.

1013. *Id.*, par. 144, p. 66.

en Amérique du Nord[1014]. Par cette présomption de consentement, le régime proposé par la CRDA se rapproche de la solution retenue en Europe de l'Ouest. Cependant, il en diffère sous un autre rapport, puisqu'il oblige l'hôpital à tenter de consulter la famille, dont l'opposition est déterminante, peu importe les raisons qui la motivent[1015].

Les recommandations de la CRDA ont déclenché des réformes législatives. Entre 1978 et 1985, les huit États de l'Australie ont adopté pour l'essentiel les recommandations de la CRDA ; la majorité d'entre eux ont expressément établi, à l'égard des donneurs potentiels n'ayant pas exprimé leur volonté, la règle de la présomption de consentement sous réserve de l'opposition de la famille[1016]. Comme, dans la plupart des cas, la famille doit être consultée, on a voulu veiller à ce que les hôpitaux s'acquittent de cette fonction sociale en faisant preuve à la fois de délicatesse et d'efficacité[1017]. La recommandation de la CRDA concernant la vente des tissus humains — interdiction de contreparties financières pour l'obtention de tissus humains, mais possibilité de remboursement des frais liés au traitement des tissus et des dépenses du donneur — a également été mise en œuvre[1018].

V. Problèmes internationaux

Les progrès de la technologie de remplacement des tissus humains, qui ont entraîné récemment des réformes législatives dans plusieurs pays, ont également eu des répercussions

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1014. Comparer la section IV et le texte accompagnant la note 1007, *supra*.

1015. Comparer la section III et le texte accompagne les notes 970 à 973, *supra*.

1016. *Transplantation and Anatomy Ordinance 1978*, 1978 L. Austr. Cap. Terr., n° 44, art. 27 ; *Transplantation and Anatomy Act 1979*, 1979 S. Qld, n° 74, art. 26 ; *Human Tissue Act, 1982*, 1982 A. Vic., n° 9860, art. 26 ; *Human Tissue Transplant Act 1979*, 1979 N. Terr., n° 121, art. 18 ; *Human Tissue and Transplant Act, 1982*, 1982, S. W. Austr., n° 116, art. 22 ; *Anatomy (Human Tissue) Amendment Act, 1983*, 1983 S. N.S.W., n° 165, art. 3 ; *Transplantation and Anatomy Act, 1983*, 1983 S.L. S. Austr., n° 11, art. 21 ; *Loi de 1985 relative aux tissus humains*, 1985-86, S.L. Tasm., n° 118, art. 23; (1987) 38:3 *R.I.L.S.* 549. Contrairement à la quasi-présomption de consentement retenue dans la plupart des États de la fédération australienne, il semble ressortir du libellé des lois de l'Australie de l'Ouest et de la Tasmanie que si l'hôpital n'est pas en mesure de retracer les membres de la famille d'un patient n'ayant pas exprimé sa volonté pour s'assurer de l'absence d'opposition de leur part, le prélèvement des tissus n'est pas possible. Voir les lois de l'Australie de l'Ouest et de la Tasmanie, précitées, par. 22(3) et 23(2), respectivement.

1017. Voir NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL, *A Code of Practice for Transplantation of Cadaveric Organs*, Canberra, le Conseil, 1982, pp. 8-9 ([TRADUCTION] « Toute demande devrait être présentée avec la délicatesse requise et en pensant au désarroi des parents. Dans la mesure du possible, on devrait les rencontrer pour leur demander leur avis, mais dans certains cas il faudra se résoudre à discuter de la question au téléphone. [. . .] On a constaté, dans la pratique, que parfois les parents refusent la première fois qu'on les aborde, mais changent d'idée par la suite, après y avoir pensé et s'être faits à l'idée. Il convient de se rappeler que lorsque l'autorisation est donnée par les parents, il s'agit d'un don de la part non seulement du défunt, mais également de leur part à eux. Il faudrait également songer à venir en aide aux familles frappées par le deuil, car il est bien établi maintenant que le taux de maladie et de mortalité augmente dans l'année suivant la perte non acceptée d'un être cher. »).

1018. Comparer CRDA, *op. cit.*, note 1010, par. 178, p. 87 (la Commission a recommandé que la loi interdise le versement d'argent pour le prélèvement de tissus, sauf le remboursement des frais connexes, ou des frais du fournisseur ayant procédé à la transformation ou à la préparation des tissus donnés, en vue d'une utilisation médicale) et les interdictions relatives à la vente des tissus figurant dans les lois citées à la note 1016, *supra*.

sur le plan des rapports entre les nations. En effet, certaines craintes concernant divers aspects de l'application de cette technologie (protection des receveurs, commercialisation, surveillance) ont déclenché des initiatives qui traduisent l'évolution du droit international et des principes sous-jacents.

A. Échanges internationaux

Les variations des besoins nationaux en matière de tissus humains peuvent nécessiter le recours aux échanges internationaux. Au début du XIX[e] siècle, par exemple, le manque de cadavres aux fins d'anatomie a parfois été pallié par des échanges entre pays (Canada et États-Unis ; Irlande, Écosse et Angleterre[1019]). L'apparition de nouveaux besoins médicaux a donné lieu à de nouvelles pratiques d'importation et d'exportation. En 1987, un bébé anencéphale moribond né en Ontario (bébé Gabriel) a contribué à élargir le bassin américain de donneurs, lorsque certains de ses organes ont été transplantés dans le corps d'un nouveau-né en Californie (bébé Paul)[1020]. En 1988, neuf pour cent des os fournis par la banque d'os de l'Université de Toronto pendant une période de six mois ont été exportés vers d'autres pays, dont l'Australie[1021]. En deux ans, soit en 1988 et en 1989, plus de quatre-vingt-dix reins, cœurs et foies ont par ailleurs traversé la frontière canado-américaine[1022]. Depuis des années, on importe du sperme humain au Canada pour traiter l'infertilité[1023]. La collaboration internationale, en outre, est désormais jugée « essentielle » pour satisfaire les besoins canadiens en matière de transplantation de la moelle osseuse[1024]. En résumé, le transport international d'organes vise notamment à établir un bassin élargi de donneurs et de receveurs pour mieux répondre à la situation nationale de l'offre et de la demande.

Dans certains cas, c'est parce que la technologie nationale ne permet pas de répondre aux besoins médicaux qu'il faut s'adresser à l'étranger. Par exemple, avant que l'on commence à pratiquer la transplantation du foie sur des enfants au Canada, les médecins dirigeaient les enfants vers les centres américains rapidement accessibles par avion. Et des chirurgiens canadiens ont récemment pratiqué des transplantations sur des patients venant du Japon, où les interdits religieux concernant les cadavres ont apparemment mis un frein au développement de la technique[1025]. Les contraintes tenant à la technologie

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1019. Comparer D.G. LAWRENCE, *loc. cit.*, note 4, 414 et « On the Exportation of Dead Bodies from Ireland to England and Scotland » (1828-1929), 1 *Lancet* 775 (lettre).

1020. Voir A.K. SCOTT, *loc. cit.*, note 579.

1021. « Bone Bank in Desparate Search for New "Depositors" », *The Medical Post* (21 mars 1989) 39.

1022. SBSC, *supra*, note 59.

1023. Voir Christie MCLAREN, « Large Ethnic Market in U.S. Creates High Interest in Toronto Sperm Bank », *The [Toronto] Globe and Mail* (19 mai 1990) A1, A2 (commerce de sperme entre le Canada et les É.-U.). Voir également SBSC, *op. cit.*, note 161, p. 15 (le Comité préconise que l'importation de sperme soit interdite jusqu'à l'élaboration de normes fédérales).

1024. Voir Noël A. BUSKARD, « The Canadian Unrelated Bone Marrow Donor Registry » (1990), 7 *Transplantation/Implantation Today* 42.

1025. David HELWIG, « Canadian Doctors and Japanese Tot Help Change Japanese Attitudes on Transplants » (1989), 139:1 *Journal de l'Association médicale canadienne* 1088.

peuvent également rendre nécessaire l'importation de tissus humains. Par exemple, le sort des hémophiles canadiens demeure étroitement lié à l'importation de facteurs de coagulation du sang fabriqués aux États-Unis, surtout en raison du fait que la technologie du fractionnement du sang est insuffisamment développée au Canada[1026]. De même, des spécialistes canadiens ont envoyé, de 1988 jusqu'à la fin de 1989, plus de deux cents valves cardiaques humaines à une banque américaine de tissus, chargée de leur faire subir des transformations complexes et de les entreposer jusqu'à leur utilisation par des chirurgiens du cœur au Canada[1027]. L'amélioration des techniques de conservation et de transport, ainsi que de la coordination internationale, pourraient bien accroître la fréquence des transports internationaux de tissus. Comme l'état de la technique continuera à varier selon les pays, certains d'entre eux seront, au total, tantôt des importateurs, tantôt des exportateurs, en ce qui concerne d'une part les tissus, d'autre part les bénéficiaires de transplantations.

B. Protection des receveurs

Si les échanges internationaux aident à répondre aux besoins thérapeutiques globaux, les risques qu'ils comportent se trouvent du même coup à être étendus à l'extérieur du pays exportateur. Par exemple, on a relié des facteurs de coagulation transformés aux États-Unis à la transmission des virus de l'hépatite[1028] et du sida[1029] à des hémophiles canadiens. Des règlements amiables ont également commencé à être conclus à l'égard de poursuites judiciaires intentées par des Canadiens contre le fabricant californien de valves cardiaques mécaniques défectueuses, implantées sur 8 900 patients au Canada et 39 000 autres à l'extérieur des États-Unis[1030]. Ces chiffres montrent bien quels problèmes peuvent présenter, sur le plan de l'innocuité, des techniques de remplacement de tissus dont on veut faire bénéficier des patients de par le monde, lorsque les techniques en question ne sont pas au point.

Bien entendu, les risques de maladie, de blessures et de mort découlant de l'exportation de telles techniques ne se limitent pas à l'Amérique du Nord. En 1987, des mises en garde ont été faites à l'échelle internationale à la suite de la mort d'un Américain sur qui l'on

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1026. Voir CCS, *op. cit.*, note 35, p. 17.

1027. SBSC, *supra*, note 59.

1028. *Kitchen* c. *McMullen* (1989), 62 D.L.R. (4e) 481 (C.A. N.-B.).

1029. U.S. Centers for Disease Control, « Safety of Therapeutic Products Used for Haemophilia Patients » (1988), 37:29 *Morbidity Mortality Wkly Rptr* 441, 442.

1030. Voir Christie McLaren, « Canadian Gets Settlement for Implant Worry », *The [Toronto] Globe and Mail* (13 décembre 1989) A1 ; « F.D.A. is Faulted on a Heart Valve », *New York Times* (26 février 1990) B8. Voir également, *Stangvik* c. *Shiley Inc.*, 273 Cal. Rptr. 179 (App. 4th Dist. 1990) (receveurs norvégiens et suédois), rév. accordée 800 P. 2d 858 ; *Corrigan* c. *Bjork Shiley Corporation*, 227 Cal. Rptr 247 (App. 2d Dist. 1986) (receveur australien), cert. refusé, 479 U.S. 1049. Voir en général U.S. House of Representatives, Staff Report of the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce, *The Bjork-Shiley Heart Valve: "Earn as You Learn"*, Washington (D.C.), U.S. Government Printing Office, 1990.

avait greffé un tissu infecté, prélevé et transformé en Allemagne en vue de la commercialisation, et exporté au Canada puis, de là, aux États-Unis[1031]. Le tissu en cause était une dure-mère prélevée sur un cadavre (la dure-mère est la membrane solide qui recouvre et protège le cerveau), qu'on avait utilisée pour une chirurgie reconstructive du cerveau. Malgré le rappel international des tissus suspects, d'autres décès ont récemment été signalés en Nouvelle-Zélande et en Italie[1032].

C. Vente

L'attitude de la communauté internationale en ce qui a trait à la vente de tissus semble en partie fonction de la nature du tissu en cause, du fait qu'il a ou non subi des transformations. La vente de produits sûrs et efficaces servant à remplacer des tissus humains — valves cardiaques mécaniques, par exemple — semble être jugée acceptable dans le cadre du commerce international. En revanche, la vente de dérivés du sang produits commercialement pourrait soulever plus d'objections, dans la mesure où l'on juge préférable l'utilisation de dérivés obtenus par le recours à l'altruisme ou à des transformations dénuées de tout caractère commercial. La vente de ces produits semble néanmoins être admise pour des raisons de nécessité[1033].

Ce sont — et de loin — les ventes d'organes, et d'une manière générale l'obtention de tissus humains moyennant une contrepartie pécuniaire, qui soulèvent les plus vives réticences au sein de la communauté internationale. Lorsqu'une augmentation du coût ne peut être justifiée par l'augmentation des frais afférents à la coordination du transport international d'organes, la transaction risque de sembler suspecte[1034]. Des allégations concernant la vente de reins entre des Turcs et des Britanniques ont provoqué en Grande-Bretagne l'adoption, en 1989, d'une nouvelle loi sur les transplantations d'organes[1035]. En Floride, d'anciens employés d'une banque d'yeux ont été reconnus coupables en 1989 de vol pour avoir fourni des cornées à des intérêts saoudiens, au prix de 650 $ chacune[1036]. Par ailleurs, il a récemment été fait état d'allégations concernant des ventes

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1031. Voir U.S. Centers for Disease Control, « Update: Creutzfeldt-Jakob Disease in a Patient Receiving a Cadaveric Dura Mater Graft » (1987), 36:21 *Morbidity Mortality Wkly Rptr* 324. Voir également Vijay Thadani et autres, « Creutzfeldt-Jakob Disease Probably Acquired from a Cadaveric Dura Mater Graft » (1988), 69:5 *J. Neurosurg.* 766.

1032. Voir U.S. Centers for Disease Control, « Creutzfeldt-Jakob Disease in a Second Patient Who Received a Cadaveric Dura Mater Graft » (1989), 261:8 *JAMA* 1118 ; Carlo Masullo et autres, « Transmission of Creutzfeldt-Jakob Disease by Dural Cadaveric Graft » (1989), 71:6 *J. Neurosurg.* 954.

1033. Comparer CCS, *op. cit.*, note 35, et A.F.H. Britten, *loc. cit.*, note 203, ainsi que le texte accompagnant les notes.

1034. Voir U.S. Congress, Hearings before the Subcommittee on Investigations and Oversight of the Committee on Science and Technology, *Procurement and Allocation of Human Organs for Transplantation* (7, 9 novembre 1983) Washington (D.C.), U.S. Government Printing Office, 1984 (frais Japon-États-Unis).

1035. Voir *Human Organ Transplants Act 1989*, précité, note 526.

1036. Voir *State of Florida* c. *Grant* (19 janvier 1989), Hillsborough Cnty 87-4613 (Cir. Ct). Voir également « 5 Accused of Selling Corneas », *New York Times* (12 janvier 1989) A24.

d'organes entre le Canada et les États-Unis, entre la France et les Pays-Bas, entre le Mexique et le Canada[1037].

La difficulté de mettre au jour les cas de ventes internationales d'organes et d'en établir l'existence n'a pas dissuadé les États ni les organisations internationales d'adopter des textes sur ce problème. Depuis 1980, en effet, la Grande-Bretagne[1038], l'Australie[1039], les États-Unis[1040], le Conseil de l'Europe[1041], les gouvernements provinciaux canadiens[1042], l'Association médicale mondiale[1043], des associations panaméricaines[1044] et internationales s'intéressant aux transplantation d'organes[1045] et au droit pénal international[1046], etc., ont soit déclaré la vente d'organes odieuse du point de vue moral, soit adopté des textes d'incrimination pour décourager cette pratique et punir ceux qui s'y livrent.

Faut-il voir dans ces mesures et ces prises de position le signe avant-coureur d'une règle de droit international public ? Chose certaine, en tout cas, cette réprobation de la vente d'organes est partagée par l'Organisation mondiale de la santé (OMS). En 1989, le Canada a joué un rôle de premier plan en parrainant avec d'autres une résolution de l'OMS concernant la vente d'organes, qui a finalement été appuyée par plus de cent cinquante et un pays. Le texte appelle les États membres à un effort commun en vue de mettre fin au trafic d'organes :

> La Quarante-Deuxième Assemblée mondiale de la Santé,
>
> Préoccupée par le trafic commercial d'organes de donneurs sains, qui exploite la détresse humaine et constitue un risque accru pour la santé des donneurs ;
>
> Consciente des transactions commerciales dont les transplantations d'organes font néanmoins l'objet [...]
>
> Désireuse d'empêcher l'exploitation de la détresse humaine [...]
>
> 1. DEMANDE aux États membres de prendre des mesures appropriées pour empêcher l'achat et la vente d'organes humains en vue de leur transplantation [...][1047]

1037. Voir, *supra*, le texte accompagnant les notes 461 à 463 ; Paul TAYLOR, « Kidneys Sold by Poor for Transplants, MD says », *The [Toronto] Globe and Mail* (22 août 1989) A1 ; Alexander DOROZYNSKI, « European Kidney Market » (1989), 299:6709 *Br. Med. J.* 1182.

1038. Voir *Human Organ Transplants Act 1989*, précité, note 526.

1039. Voir *supra*, note 1018.

1040. Voir NOTA, précité, note 995, al. 274*e*).

1041. Voir *supra*, note 965.

1042. Voir, par exemple, LTHM, précitée, note 839, art. 15.

1043. Voir annexe A, *infra*, pp. 228-229.

1044. PAN AMERICAN SOCIETY FOR DIALYSIS AND TRANSPLANTATION, « Document on Transplant Ethics » (1989), 5:2 *UNOS Update* 7.

1045. Voir THE COUNCIL OF THE TRANSPLANTATION SOCIETY, « Commercialisation in Transplantation: The Problems and Some Guidelines for Practice » (1985), 2:8457 *Lancet* 715.

1046. Voir ASSOCIATION INTERNATIONALE DE DROIT PÉNAL, *XIV Congrès international de droit pénal*, Vienne, l'Association, 1989, projet de résolution 3.10 (transplantation d'organes et organes artificiels).

1047. « Adoption par l'Assemblée mondiale de la Santé d'une résolution pour l'interdiction de l'achat et de la vente d'organes humains » (1989), 40:3 *R.I.L.S.* 783, extraits reproduits à l'annexe A, *infra*, p. 231.

D. Contrôles internationaux

Outre les résolutions officielles, la communauté internationale peut recourir à d'autres mesures (traités, législation nationale, codes de déontologie) pour veiller à ce que les prélèvements nécessaires pour répondre aux besoins thérapeutiques globaux se fassent de manière sûre, adéquate, rapide et acceptable du point de vue de l'éthique. Par exemple, les déclarations du Conseil international sur les transplantations et de l'Association médicale mondiale pourraient servir de base à l'élaboration d'un code de déontologie international à l'intention des médecins qui font des transplantations. Il faut aussi mentionner à cet égard les principes devant être adoptés par l'Organisation mondiale de la santé en 1991[1048]. Certes, de telles déclarations n'ont pas force de loi, mais elles peuvent néanmoins avoir un effet juridique si elles deviennent des règles de déontologie sur lesquelles se fondent des poursuites disciplinaires à l'échelle nationale, comme celles engagées par le General Medical Council de la Grande-Bretagne, à l'issue desquelles des médecins impliqués dans la vente d'organes entre la Grande-Bretagne et la Turquie ont récemment été déclarés coupables de faute professionnelle grave[1049].

Par ailleurs, les ententes internationales permettent d'agir directement sur les plans de l'offre, de la protection des patients, de la répartition des organes et de la diffusion de l'information technique, tout en veillant à la mise en œuvre de principes éthiques. Ces ententes peuvent revêtir la forme de contrats internationaux. Par exemple, le Comité canadien du sang a conclu un contrat avec des intérêts américains en vue de la transformation et de la livraison de substances sanguines utilisées pour traiter l'hémophilie[1050]. Il peut également s'agir de traités officiels. Pensons au texte adopté par le Conseil de l'Europe, qui soustrait les substances thérapeutiques humaines aux droits d'import-export, d'une part parce que, sur le plan pratique, cela favorise les échanges internationaux et, d'autre part, parce qu'on estime que de telles substances n'ont pas de prix[1051]. Alors que les autorités américaines et canadiennes ont envisagé la systématisation des transports d'organes entre les deux pays[1052], les pays de l'Europe de l'Est ont déjà conclu un traité sur l'échange d'organes[1053]. Sur le plan de la protection des patients, un traité peut reconnaître aux États contractants le droit de refuser l'importation de substances qui présentent un trop grand risque pour la santé[1054], ainsi qu'un droit d'inspection correspondant à l'obligation pour les pays exportateurs de fournir les documents propres à établir que les contrôles de qualité prévus ont bien été effectués[1055].

1048. Voir annexe A, *infra*, pp. 229-231.

1049. Diana BRAHAMS, « Kidney Sales » (1990), 335:8964 *Lancet* 906.

1050. Voir CCS, *op. cit.*, note 35.

1051. Voir CONSEIL DE L'EUROPE, *loc. cit.*, note 966.

1052. Voir *UNOS Policies: Changes as of December 6, 1988*, *op. cit.*, note 1003.

1053. Voir CONSEIL D'ASSISTANCE ÉCONOMIQUE MUTUELLE (CAEM), « Accord sur le système international de coopération dans le domaine de la transplantation rénale dénommé "Intertransplant" » (1982), 33:1 *R.I.L.S.* 24.

1054. Voir art. 20, *Accord général sur les tarifs douaniers et le commerce*, 30 octobre 1947, 55-61 *R.T.N.U.* 195 et (1947) T.I.A.S. n° 1700 (entrée en vigueur le 1er janvier 1948).

1055. Voir COMMUNAUTÉS ÉCONOMIQUES EUROPÉENNES, Directive du Conseil N° 89/381/CEE du 14 juin 1989 (concernant les dérivés du sang), *Journal officiel des Communautés européennes*, 28 juin 1989, reproduit dans (1989), 40:4 *R.I.L.S.* 943, art. 3, par. 3.

Enfin, les lois et les usages des États formant la communauté internationale contribuent, par définition, à façonner les règles et les orientations que celle-ci se donne. Nous pensons en particulier à la mesure dans laquelle la législation nationale impose des normes de sécurité à l'égard des techniques de remplacement de tissus destinées à l'étranger. Par exemple, la législation canadienne et américaine autorise l'exportation d'appareils médicaux non conformes aux normes nationales, pourvu qu'il soient adéquatement étiquetés et ne contreviennent pas aux lois du pays importateur[1056]. Cela veut dire que si des valves cardiaques de fabrication canadienne sont implantées à des patients en Europe de l'Est, les risques de défectuosité sont uniquement limités par la mise en garde sur l'étiquette apposée pour l'exportation, les normes de fabrication ou les normes professionnelles en vigueur au Canada, les normes législatives du pays importateur et la faible menace de poursuites judiciaires[1057]. Or, la protection des patients serait sans doute mieux garantie par l'adoption de normes minimales rigoureuses à l'échelle internationale, qui seraient reprises dans le droit interne des pays exportateurs et importateurs. Et cela ne vaut pas seulement pour le problème de la sécurité. À défaut de l'établissement de règles de droit internationale précises, on luttera sans doute plus efficacement contre le trafic d'organes par l'établissement d'interdictions complémentaires dans les États concernés[1058], surtout si ces interdictions s'appliquent aussi à l'extérieur de leur territoire.

VI. Tendances internationales

D'une manière générale, la perspective du droit comparé et du droit international permet de considérer sous un jour plus large les problèmes que suscitent les prélèvements et les transplantations à l'échelle nationale. Par ailleurs, on est à élaborer des mesures législatives, tant sur le plan national que sur le plan international, en vue de garantir que ces interventions se font d'une manière sûre, adéquate, rapide et acceptable sur le plan éthique.

La cadence de l'activité législative porte à croire que le cadre juridique dans lequel s'inscrivent les prélèvements et les transplantations de tissus humains est en train de se transformer quelque peu. Au cours de la dernière décennie, plusieurs États ont modifié les textes régissant ce domaine. Ces modifications, dans une large mesure, visaient à faciliter et à réglementer le processus, devant l'augmentation phénoménale du nombre de transplantations et la pénurie de tissus qui en a résulté. Dans certains pays, on a commencé à évaluer les conséquences des techniques de remplacement des tissus humains sur la biotechnologie.

Il semble que, dans les États sur lesquels a porté notre étude, les objectifs poursuivis soient les mêmes, les différences ayant surtout trait aux détails d'application. La Grande-Bretagne, la France, l'Australie, le Conseil de l'Europe et les États-Unis semblent tous

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1056. Voir LAD, précitée, note 738, art. 37. Voir également 21 U.S.C., al. 381*e*), discuté dans OTA, *Federal Policies and the Medical Devices Industry*, Washington (D.C.), OTA, 1984, pp. 216, 219.

1057. Voir *Stangvik* et *Corrigan*, précités, note 1030 et *Kitchen*, précité, note 1028.

1058. Voir, *supra*, note 929 et le texte l'accompagnant.

d'opinion que la vente d'organes est si odieuse du point de vue de l'éthique qu'elle doit être interdite par le droit pénal. Si la teneur exacte des règles peut différer, on insiste presque partout sur le fait que, tout en poursuivant l'objectif de la préservation de la vie au moyen des greffes et des transplantations, il importe de respecter les droits de la personne, les dépouilles, les croyances religieuses et les attentes de la famille. Dans la plupart de ces pays, on a adopté le critère de la mort cérébrale et l'on exige de plus en plus que les hôpitaux mettent sur pied des mécanismes propres à faciliter le don de tissus humains.

Les différences les plus marquées concernent les prélèvements sur des patients morts sans avoir exprimé leur volonté, et en particulier le rôle attribué à la famille par le droit. Les lois axées sur les notions de consentement exprès et de demande obligatoire en vigueur en Australie, en Grande-Bretagne et aux États-Unis exigent généralement la participation de la famille, contrairement aux régimes fondés sur la présomption de consentement instaurés dans les pays de l'Europe de l'Ouest. Mais dans ce dernier cas, il semble que dans la pratique, la famille soit consultée, ce qui remet peut-être en cause l'intérêt des régimes reposant strictement sur la présomption de consentement. De telles différences, si légères soient-elles, n'en sont pas moins indicatrices des tensions et des valeurs qui sous-tendent ces choix législatifs délicats.

Elles nous enseignent par ailleurs un grand principe, tout simple au demeurant : quelle que soit la politique ou le régime législatif retenu, il demeure sujet aux croyances, aux coutumes et aux attitudes relatives au corps humain, qui — constantes mais ayant aussi connu une certaine évolution — ont influé sur la condition humaine, depuis l'ère de l'anatomie jusqu'à celles des transplantations et de la biotechnologie.

CHAPITRE CINQ

Options et recommandations en vue d'une réforme

I. Forces et limites du droit

Nous avons exposé dans les chapitres précédents les forces, les limites et le rôle du droit par rapport à la demande de la médecine quant à l'utilisation du corps humain. Cette demande, pour sa part, évolue au fil des innovations de la technologie et de la transformation des besoins thérapeutiques. Le droit et la médecine ont parfois suivi, parfois précédé l'évolution des conceptions sur le corps humain, pendant que la société passait de l'ère de l'anatomie, au XIX[e] siècle, à l'ère des transplantations et de la biotechnologie où nous nous trouvons maintenant.

Dans une perspective historique, bon nombre des questions soulevées au cours des débats concernant la *Loi sur l'anatomie* (1843) de la Province du Canada[1059] demeurent actuelles. En effet, la société s'interroge encore aujourd'hui sur les enjeux touchant la vente et la propriété des éléments du corps humain, le respect du cadavre, le fondement et l'équité des dispositions législatives visant à répondre à la rareté des tissus, la façon dont le droit pourrait aider la médecine à sauver des vies, et non entraver ses efforts. Mais les problèmes diffèrent du point de vue de leur importance, de leurs implications et du contexte dans lequel ils s'inscrivent.

En fait, un siècle et demi après les premiers débats ayant eu lieu au Canada sur des textes régissant les prélèvements, les interrogations et la clameur internationale suscitées par l'affaire *Moore*[1060] semblent pouvoir être assimilées à des rites de passage marquant l'entrée dans un nouvel âge. La première phase de ce passage semble être transitoire. Au moment où elle s'engage dans l'ère de la biotechnologie, la société se voit obligée de tenter de définir les règles et les modalités d'application précises d'au moins trois régimes juridiques appelés selon toute vraisemblance à orienter, dans l'avenir prévisible, les pratiques touchant les prélèvements de tissus et d'organes et le recours à des solutions mécaniques ou synthétiques pour remplacer des organes ou des tissus humains. Le tableau 3, ci-dessous, expose les grands traits de ces trois régimes juridiques.

Comme l'indique le tableau 3, le régime « naturel » vise le prélèvement et l'utilisation de tissus naturels, comme le sang et les organes. Ce régime est fondé sur le don, comme

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1059. Voir *supra*, pp. 2-3, 148-150.

1060. Voir *supra*, note 426.

TABLEAU 3. Prélèvement de tissus et techniques de remplacement : régimes juridiques

Régimes	Tissus et substances	Modalités	Stockage	Normes de sécurité	Éthique et principes	Marché
« naturel »	Tissues et substances • lait • sang • peau • organes • placenta • gamètes	Consentement • donneur et receveur Exceptions • cadavres non réclamés • autopsies par médecin légiste • urgence (Québec) Abandonnés • recherche et destruction	Conservation • sang • substances reproductives • moelle osseuse • cellules Conservation pour • la société, et • le donneur et sa famille = déposants	Normes professionnelles • lait Poursuites privées (peu nombreuses)	• Don • Pas de commercialisation • Pas de droit de propriété	• Pas de profit (avec certaines exceptions)
« mixte » — substances biologiques et biotechnologiques	Tissues, substances et produits • hormones — traitées, synthétiques, obtenues par l'ADN recombinant • valves cardiaques (prothèses biologiques) • lignées cellulaires et cellules cultivées • équivalents de la peau et d'organes, obtenus par l'ADN recombinant • transplantations génétiques — ADN recombinant	Consentement • donneur/source ? et receveur Abandonnés et commercialisés • affaire *Moore*	Traitement et conservation • ADN • veines (prothèses biologiques) • sperme : affaire *Parpalaix* • valves cardiaques Conservation pour • la société, et • le donneur et sa famille = déposants	Normes professionnelles Législation fédérale : médicaments, substances biologiques et instruments médicaux • règlements sur le sang et le plasma • médicaments fabriqués grâce à l'ADN recombinant (insuline, hormone de croissance) • sperme traité et congelé ? • moelle osseuse et cartilages traités ? • valves cardiaques (prothèses biologiques) ? • dure-mère traitée ?	• Don/pas de commercialisation ? • Fabrication/ventes ? • Droit de propriété/pas de droit de propriété	• Profit, avec certaines limites • Quelques brevets
« artificiel » et mécanique	Produits • rein artificiel • valves cardiaques mécaniques • sang synthétique • veines (prothèses biologiques) • verres de contact	Consentement • receveur • pas de donneur	Traitement-fabrication • plasma • produits dérivés du sang • veines • verres de contact « vivants »	Législation fédérale sur les instruments médicaux • sécurité et efficacité des appareils et produits médicaux, par ex. : • stimulateurs cardiaques • cœurs et reins artificiels • pompes à insuline • vaisseaux sanguins synthétiques • verres de contact synthétiques	Fabrication/traitement et ventes Commerce Droit de propriété	Profit • recherche • brevets • marketing • ventes

le suggère l'emploi du mot « donneur ». Il se caractérise, sur le plan éthique et sur le plan des principes, par l'exclusion de toute notion de commerce, de profit et de propriété.

Le cœur et le rein artificiels sont les éléments types du deuxième régime juridique, celui de l'utilisation d'appareils mécaniques ou de tissus synthétiques. Ici, pas de « donneur » : sont visés des produits inventés, conçus, fabriqués, mis en marché et vendus suivant les règles prévues par les lois fédérales sur les brevets et les instruments médicaux, qui régissent aussi l'attribution de licences[1061]. Dans le cadre de ce régime, ni le discours éthique, ni le discours politique ne s'opposent aux investissements, à la commercialisation et aux bénéfices, du reste monnaie courante.

Pendant plusieurs années, la société canadienne s'est fondée sur des éléments de ces deux régimes pour en définir un troisième, une sorte de régime « mixte ». Celui-ci, qui fonctionne parallèlement aux deux autres, concerne des tissus humains transformés en produits thérapeutiques. Les sociétés pharmaceutiques, et désormais les entreprises de biotechnologie, transforment du sang, des tissus et des substances humaines en médicaments, en succédanés de la peau, en veines bioprosthétiques, en plasma sanguin congelé, etc. Un grand nombre de ces produits « biologiques » et biotechnologiques sont brevetés, réglementés et vendus en conformité avec des lois fédérales. Les termes « don », « commerce », « substances humaines » et « produits bio-synthétiques » sont utilisés dans le discours éthique et politique relatif à ce régime mixte.

Il existe une tendance manifeste et croissante à recourir aux techniques biosynthétiques et bioprosthétiques de remplacement des tissus[1062]. Les progrès de la biotechnologie et de la médecine entraînent une multiplication du nombre de tissus thérapeutiques paraissant s'inscrire dans ce régime mixte, mais il n'est pas toujours facile de déterminer si ces produits devraient obéir aux règles particulières applicables à un régime ou à l'autre. En conséquence, la société observe, dans des litiges semblables à l'affaire *Moore*[1063], les parties se fonder, qui sur le régime « naturel », qui sur le régime « artificiel », pour débattre la nature et les conséquences juridiques précises de l'utilisation de tissus. De tels conflits sont le reflet d'un débat plus large au sein de la société, débat qu'elles contribuent du reste à alimenter. Le dialogue entre le droit, la médecine, et désormais la bioéthique, se poursuit ; il n'est sans doute pas près de prendre fin.

La teneur du dialogue, son caractère, portent également à croire que la pénurie actuelle de tissus humains est autant une abstraction sociale qu'un fait empirique[1064]. Les besoins médicaux trouvent leur origine dans la maladie et les blessures ; mais il n'en est pas moins vrai que l'existence de techniques chirurgicales ultra-perfectionnées, d'une médecine de haute technologie, contribuent à amplifier ces besoins, à les transformer en une demande

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1061. Voir *supra*, pp. 24-26, 137 et 143.

1062. Voir *supra*, pp. 26, 137-142.

1063. Voir *Moore* (1990), précité, note 426.

1064. Sur la pénurie d'organes considérée comme un concept arbitraire, voir George J. ANNAS, « The Paradoxes of Organ Transplantation » (1988), 78:6 *Am. J. Pub. Health* 621.

sociale. Du point de vue de l'offre, le nombre de décès par année amène à conclure qu'on pourrait théoriquement prélever sur des cadavres un nombre suffisant de tissus et d'organes pour répondre aux besoins. Qu'est-ce qui empêche alors la société de procéder, d'une façon simple et efficace, à ces prélèvements qui permettraient de sauver des vies humaines ?

Quand on tente de puiser dans cette réserve, toutefois, on se heurte inévitablement à des obstacles d'ordre technologique et d'ordre éthique-juridique. La société ne dispose pas actuellement des moyens techniques qui permettraient d'entreposer ou de conserver à long terme les cœurs, les reins ou les poumons prélevés[1065]. Le prélèvement d'organes, contrairement à celui de simples tissus, doit donc s'effectuer dans des situations d'urgence, ou presque, sur un patient qui vient de mourir. Et même si cette difficulté technique s'estompait, il faudrait encore compter avec des considérations d'ordre éthique-juridique.

Il s'agit de considérations à la fois simples et complexes, qui transcendent tout dualisme analytique. Car le prélèvement d'organes, de tissus, n'est pas une simple compétition entre la vie et la mort (entre un vivant et un mort), entre la science pure et dure et les sentiments, entre la médecine et la mythologie de la mort. La société veille à la protection d'une gamme de plus en plus large de valeurs et de droits fondamentaux. Le respect de la vie privée, de l'autonomie, de la dignité humaine, du principe de bienfaisance, des pratiques et croyances religieuses, des différents points de vue sur l'éventuelle obligation de respecter comme toute autre personne le donneur potentiel agonisant mais encore en vie, le souci de préserver la vie et la santé — tout cela contribue à l'élaboration du processus complexe dans le cadre duquel les tissus et les organes prélevés sur des cadavres peuvent être utilisés pour répondre aux besoins thérapeutiques de personnes vivantes[1066]. La nature et l'importance relative de ces valeurs et de ces principes ne sont pas toujours faciles à déterminer de façon précise, et elles sont parfois contestées. Certaines des valeurs en question font l'objet de garanties juridiques, les autres sont fondées sur un principe éthique. Prises comme un tout, elles définissent et informent le cadre éthique-juridique dans lequel s'inscrivent les prélèvements de tissus et d'organes.

Ce cadre éthique-juridique et les valeurs contradictoires qui le sous-tendent montrent — de façon un peu trop brutale, parfois — que si le souci de préserver la vie et la santé l'emporte la plupart du temps, il n'est pas absolument déterminant[1067]. S'il en était autrement, le système de prélèvement de tissus humains serait peut-être plus efficace, et l'existence humaine serait sans doute plus simple, mais en même temps moins riche. La complexité de ce cadre, les valeurs entremêlées et dans certains cas contradictoires qui le constituent, font qu'il est indissociable de notre identité personnelle et collective, ne fût-ce que parce qu'il reflète et organise la réflexion et les choix.

Ce cadre met donc également en lumière le rôle utile mais nécessairement limité du droit dans l'élaboration de solutions juridiques à la pénurie de tissus humains. Le droit

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1065. Voir *supra*, pp. 27-32.

1066. Voir *supra*, pp. 71-72, 158-166.

1067. Voir *supra*, pp. 71-72.

est dépourvu des outils qui lui permettraient de résoudre les dilemmes techniques de la médecine, les conflits philosophiques de l'éthique[1068]. Il est plutôt apte à définir les obligations et les droits minimaux au chapitre des prélèvements et des transplantations, et d'ainsi nous aider à élaborer les grands principes applicables en la matière.

Le droit peut tendre à exprimer les attitudes et les valeurs traditionnelles à l'égard du corps humain, lesquelles peuvent — et devraient peut-être — être remises en question par les idées et les valeurs différentes défendues par la science médicale. Car si les difficultés et les interrogations engendrent de la confusion et de l'incertitude, elles nous donnent du même coup l'occasion de repenser, de modifier ou de réaffirmer les règles, les pratiques et les valeurs actuelles.

C'est dans cet esprit — celui d'une remise en question des fondements juridiques et éthiques des régimes de prélèvement traditionnels et en voie d'élaboration dans divers pays, des grands principes qui les sous-tendent — que nous proposons des recommandations sur certains des problèmes étudiés ci-dessus. Nous savons par ailleurs que des travaux importants sont en cours, dans le même domaine, à l'Organisation mondiale de la santé[1069], dans des pays voisins et éloignés et dans les provinces du Canada[1070].

Notre étude nous a également persuadés que la recherche de solutions universelles est malheureusement illusoire. En effet, le caractère profondément philosophique de bon nombre de ces enjeux concernant la vie et la mort — surtout dans le cas du régime de prélèvement de tissus naturels — amène à conclure que, pour une bonne part, les divers intérêts, valeurs et approches en présence ne se prêtent pas à l'élaboration d'une formule universelle. Cela ne veut pas dire que le droit ne soit pas en mesure d'offrir des options et des solutions acceptables. Bien au contraire, il peut même offrir les meilleures solutions. Mais il est indispensable, à notre sens, que ces solutions découlent de valeurs dont le caractère fondamental est reconnu de longue date, ainsi que de principes et d'objectifs existant d'une façon permanente au sein de la société canadienne.

II. Objectifs et principes généraux — élaboration d'un régime sûr, adéquat, juste et efficace

RECOMMANDATION

1. L'établissement d'un régime de prélèvement et d'offre de tissus humains qui soit à la fois sûr, adéquat, équitable et efficace devrait constituer un objectif national commun, pour l'élaboration de la législation comme de la politique à ce chapitre.

1068. Voir *supra*, pp. 39-41, 71-72.

1069. Voir *supra*, pp. 187-188.

1070. Voir *supra*, pp. 157-158.

La Commission est d'avis que tous ceux qui jouent un rôle au Canada dans le domaine de l'utilisation thérapeutique de tissus devraient travailler à la réalisation de ces objectifs nationaux communs — qu'ils appartiennent au secteur public ou au secteur privé. Un engagement à l'égard de l'un ou l'autre de ces grands objectifs n'impose pas, en soi, la mise en œuvre de lignes de conduite précises. Dans une large mesure, cela s'explique par le fait que bien peu (voire aucune) des valeurs s'inscrivant dans notre cadre éthique-juridique sont absolues ou déterminantes par essence. Il faudrait plutôt parler d'une tension dynamique, saine et souvent conflictuelle entre les objectifs, les principes et les valeurs sous-jacentes. La recherche d'une offre « adéquate » de tissus, par exemple, doit tenir compte de diverses autres préoccupation — protection des patients, droits de la personne, efficacité.

De la même manière, l'objectif d'efficacité doit être défini au regard de notions de justice, ancestrales et contemporaines, concernant la répartition de ressources médicales insuffisantes[1071]. L'efficacité suppose l'établissement d'un système de prélèvements efficace à l'échelon régional comme à l'échelon national. Elle implique en outre la nécessité de veiller à la « rentabilité » des interventions médicales. En ce sens, la société doit intensifier le débat public et éthique, se doter de meilleurs outils d'analyse économique et d'évaluation des techniques médicales, afin d'apprécier la rentabilité et la répartition entre générations des coûts et des avantages des greffes et transplantations et d'autres interventions relevant de la haute technologie médicale, ainsi que les conséquences sur le plan de la recherche[1072]. Ces outils permettront de définir et de préciser le rôle du droit.

RECOMMANDATION

2. L'élaboration et la réforme de la législation touchant les régimes de prélèvement et de remplacement de tissus humains devraient être fondées sur les principes suivants :

***a*) l'autonomie de la personne, l'inviolabilité et l'intégrité du corps humain ;**

***b*) l'altruisme et l'encouragement aux prélèvements librement consentis ;**

***c*) la gratuité et l'universalité ;**

***d*) la préservation et la protection de la vie ;**

***e*) le respect dû aux mourants, aux morts et à leur famille.**

La Commission est convaincue que ces cinq principes de base favoriseront la réalisation de l'objectif énoncé à la recommandation 1, et orienteront l'élaboration et la réforme de la législation touchant les régimes de prélèvement et de remplacement de tissus humains. Ils sont pour la plupart déjà enchâssés dans le droit actuel ainsi que dans la politique officielle. Dans certains cas, il s'agit de prolongements ou de perfectionnements par rapport

1071. Voir *supra*, pp. 37-39, et les observations sur les recherches à effectuer, *infra*, p. 217.

1072. Voir *supra*, pp. 37-39.

à des valeurs ancestrales ou à des mesures adoptées par le passé dans ce domaine, avec les adaptations nécessaires vu l'évolution de la société. Ici encore, il existe une tension aussi marquée que saine entre certains d'entre eux — une tension qui oblige la société à déterminer leur importance relative, voire à choisir l'un au détriment de l'autre.

A. Autonomie de la personne, inviolabilité et intégrité du corps humain

Le *Code criminel*, le droit civil, la législation provinciale et la *Charte canadienne des droits et libertés* donnent effet au principe éthique de l'autonomie de l'être humain. Le droit de ne subir aucun contact physique auquel on n'a pas consenti protège l'intégrité corporelle et l'intimité, tout en favorisant le respect de la qualité de personne et la dignité humaine. Le droit, la médecine et la société se doivent tout particulièrement de protéger les enfants, les handicapés mentaux, les patients privés de la capacité juridique et toutes les autres personnes incapables de refuser une atteinte à leur intégrité corporelle ou d'y consentir ; ils doivent également veiller à ce que ces personnes reçoivent les soins requis et soient traitées avec respect.

B. Altruisme et encouragement aux prélèvements librement consentis

Le don désintéressé est un idéal public louable. Le don de sang, d'organes ou d'autres tissus susceptibles de sauver des vies est depuis longtemps considéré comme la solution à privilégier du point de vue de l'intérêt public, et il devrait continuer d'en être ainsi[1073]. L'altruisme et le don volontaire devraient être encouragés et pratiqués. On peut les concrétiser par un recours accru à des initiatives imaginatives et éducatives s'adressant à la fois au public et aux professionnels de la santé.

C. Gratuité et universalité

Dans ce contexte, le mot « gratuité » revêt une signification spéciale. Depuis près de dix ans, l'organisme responsable de l'application de la politique nationale du sang entend par « gratuité » le principe suivant lequel les patients recevant des produits sanguins ne devraient pas avoir à verser de l'argent[1074]. Il ressort en effet des choix faits par la société canadienne — respect des principes de justice fondamentale, accès universel aux services de santé — que la capacité individuelle de payer ne devrait pas déterminer l'accès à des ressources thérapeutiques insuffisantes, qu'il s'agisse de tissus et d'organes humains ou de produits dérivés. Ces choix ont également une incidence en ce qui a trait aux donneurs.

1073. Voir *supra*, pp. 45-48.

1074. Voir le *Rapport annuel du Comité canadien du sang présenté à la Conférence provinciale-territoriale des ministres de la Santé*, *op. cit.*, note 38, annexe A (Résumé des principes) (« Ce principe [la gratuité] suppose que les personnes qui reçoivent du sang, des produits sanguins et des fractions plasmatiques n'aient pas à payer pour ces produits dispensés au Canada dans le cadre des régimes d'assurance-maladie. »).

Le principe voulant que le don n'entraîne pour eux ni profit ni perte sur le plan financier signifie que tout donneur potentiel, peu importe sa situation socio-économique, devrait se voir donner l'occasion de donner libre cours à son altruisme. Ainsi, le remboursement des frais supportés par le donneur, en vertu d'une quelconque assurance[1075] ou par d'autres mécanismes, est un moyen légitime de veiller à ce que tous, riches et pauvres, soient traités sur le même pied. Une politique de don, si elle est bien établie et appuyée par des mesures pratiques, réduit le risque que le corps humain soit assimilé à une simple marchandise.

D. Préservation et protection de la vie

La législation et la politique relatives aux prélèvements sont axées sur le souci de préserver et de protéger la vie humaine, et devraient continuer de l'être.

E. Respect dû aux mourants, aux morts et à leur famille

Il y a lieu de respecter les mourants et les morts, ainsi que les réactions affectives et les croyances religieuses de l'entourage familial. Cette obligation juridique s'accorde avec les principes hippocratiques, suivant lesquels il faut traiter le mourant avec dignité, respecter l'intégrité de la forme humaine après la mort et réconforter la famille, en répondant aux besoins et aux souhaits de ceux qui viennent de perdre un être cher.

III. Prélèvements sur des personnes vivantes

A. Maintien des principes actuellement suivis

RECOMMANDATION

3. Il y aurait lieu, d'une manière générale, de maintenir les principes régissant actuellement les prélèvements de tissus et d'organes sur des personnes vivantes — consentement libre et éclairé, proportionnalité du risque couru et des avantages attendus.

D'une manière générale, la législation et la politique relatives aux prélèvements sur des personnes vivantes sont axées sur l'obligation d'obtenir un consentement libre et éclairé et la nécessité d'une proportionnalité entre le risque de préjudice et les avantages attendus, surtout dans le cas des interventions chirurgicales portant atteinte à l'intégrité corporelle. Dans l'ensemble, ces règles s'accordent avec les principes énoncés ci-dessus, et favorisent leur application.

1075. Voir *supra*, le texte accompagnant la note 489.

B. Prélèvements et atteintes à l'intégrité corporelle

RECOMMANDATION

4. Le *Code criminel* devrait être modifié par l'adjonction d'une clause précisant que les dispositions sur les atteintes à l'intégrité corporelle sont inapplicables à l'égard des prélèvements de tissus ou d'organes auxquels le donneur a consenti librement et en pleine connaissance de cause, pourvu que le risque ne soit pas hors de proportion avec les avantages attendus.

Un rapprochement peut être fait entre la nécessité de protéger, par le droit pénal, la vie et l'intégrité corporelle des donneurs de tissus ou d'organes, et les cas où la recherche médicale et l'expérimentation sur l'être humain ne comportent aucun bienfait pour le sujet. La Commission a déjà exprimé son point de vue sur ce dernier problème[1076], et elle estime de même que les dispositions du *Code criminel* portant sur l'atteinte intentionnelle à l'intégrité corporelle[1077] ne devraient pas être applicables aux prélèvements de tissus et d'organes si les deux condition suivantes sont remplies : (1) le donneur a consenti en toute connaissance de cause à l'intervention ; (2) le risque n'est pas hors de proportion avec les avantages attendus. L'appréciation du rapport risque-avantages devrait être fondée à la fois sur des éléments physiques et sur des éléments psychologiques[1078]. Le don de tissus et d'organes constitue une intervention médicale entreprise à des fins thérapeutiques et, à ce titre, il est visé par l'exception de l'« acte médical » figurant au chapitre des infractions contre l'intégrité du corps humain proposées récemment par la Commission dans le document de travail n° 61[1079].

RECOMMANDATION

5. Les prélèvements effectués sur des personnes incapables de donner un consentement devraient être considérés comme légitimes pourvu qu'un tiers indépendant (tribunal, comité, ombudsman, etc.) se soit, dans chaque cas, assuré que les conditions suivantes sont remplies :

***a*) dans le cas de la moelle osseuse et des tissus non susceptibles de régénération, le donneur et le receveur doivent être apparentés ;**

***b*) on a épuisé toutes les autres possibilités de prélèvements et de traitements médicaux ;**

1076. Voir Document de travail n° 61, *op. cit.*, note 295 ; Rapport n° 31, *op. cit.*, note 116, p. 72 ; Document de travail n° 26, *op. cit.*, note 370, pp. 66-69.

1077. Comparer le par. 7(1) et les al. 7(2)*a*) et *b*) du Rapport n° 31, *op. cit.*, note 116, pp. 69, 71 et les dispositions actuelles du *Code criminel* concernant les voies de fait ayant pour effet de mutiler ou de défigurer une personne (art. 244, 265, 266), discutées, *supra*, pp. 101-109.

1078. Voir Rapport n° 31, *op. cit.*, note 116, p. 72 ; Document de travail n° 26, *op. cit.*, note 370, pp. 66-69.

1079. Document de travail n° 61, *op. cit.*, note 295, p. 39.

c) l'intervention ne comporte aucun risque sérieux pour le donneur ;

d) le risque n'est pas hors de proportion avec les avantages attendus ;

e) le consentement du tuteur a été obtenu ;

f) le consentement du donneur a été obtenu lorsque la chose est possible, et son refus doit toujours être respecté.

Le don d'organes par des mineurs et des personnes atteintes de déficience mentale pose des problèmes délicats. Le cas du mineur doué de discernement et de la capacité de comprendre et d'apprécier le risque, les avantages et les conséquences d'un don de tissus ou d'organes, est semblable à celui de l'adulte dans les mêmes circonstances[1080]. Par ailleurs, dans le cas de donneurs potentiels incapables de donner un consentement, et donc de veiller à leur propre protection, de telles interventions peuvent s'accorder avec l'intérêt public et se justifier par des motifs de nécessité[1081], dans des circonstances exceptionnelles, pourvu que certaines conditions soient remplies. En premier lieu, le principe de l'inviolabilité et de l'intégrité du corps humain — et son corollaire éthique, la nécessité de ne pas causer de préjudice — supposent que l'intervention ne doit pas comporter de risques sérieux pour le donneur[1082]. Ces risques varient en fonction de l'atteinte à l'intégrité corporelle et du caractère irréversible de l'intervention : il y a par exemple de grandes différences, sur ce plan, entre le prélèvement de sang, de moelle osseuse et d'un rein. C'est pourquoi il faut en deuxième lieu, pour veiller à l'entière protection des personnes incapables, s'assurer que des prélèvements ne sont effectués sur elles qu'en dernier recours — autrement dit, après avoir épuisé toutes les autres possibilités de prélèvement ou de traitement. En troisième lieu, les principe du respect de l'intégrité du corps humain et de la préservation de la vie, qui se reflètent dans le corollaire éthique de la bienfaisance[1083], incitent à conclure que les transplantations peuvent parfois être justifiées par les avantages du don. Ce serait le cas lorsque l'intervention ne comporte aucun risque sérieux pour le donneur et que la personne incapable est en mesure d'apprécier les avantages psychologiques potentiels du don[1084] ainsi que le caractère vital de la transplantation pour le receveur. C'est dans le cas des dons entre parents que la possibilité de bienfaits psychologiques semblerait la plus grande. En quatrième lieu, le fait d'exiger le consentement du tuteur et l'absence d'opposition de la part du donneur potentiel contribue à garantir le respect des volontés de la personne incapable et des personnes ayant le droit de s'exprimer en son nom. Ces règles correspondent, à peu de choses près, à celles énoncées par la Commission de réforme du droit de l'Australie[1085] et le Conseil de l'Europe[1086] — les

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1080. Voir *supra*, pp. 75-76, 101-110.

1081. Voir *supra*, note 552.

1082. Voir T.L. Beauchamp et J.F. Childress, *op. cit.*, note 236, p. 120, dans la perspective de la non-malfaisance, et pp. 55-56 et 108, *supra*.

1083. Voir *supra*, note 285 et pp. 43, 56-59 et 108.

1084. *Ibid.*

1085. Voir les recommandations de la Commission de réforme du droite de l'Australie, résumées, *supra*, note 555.

1086. Voir les recommandations du Conseil de l'Europe, résumées, *supra*, note 556.

deux organismes ont proposé d'interdire d'une manière générale les prélèvements sur des personnes incapables, avec des exceptions bien précises assorties de garanties rigoureuses. La Conférence sur l'uniformisation des lois au Canada a également proposé récemment des règles allant dans le même sens[1087].

IV. Définition de la mort cérébrale — nouveau-nés anencéphales

RECOMMANDATION

6. Le critère de la « cessation irréversible de l'ensemble des fonctions cérébrales », proposé par la Commission il y a dix ans dans son rapport n° 15, ne devrait pas être modifié en vue de faciliter les prélèvements d'organes sur des nouveau-nés anencéphales mourants ou sur tout autre patient ne satisfaisant pas pleinement à ce critère.

Au Canada, l'anencéphalie entraîne la mort d'environ cinquante nouveau-nés par an[1088]. Cette malformation est caractérisée par l'absence d'encéphale à la naissance. Les nouveau-nés qui en sont atteints et qui naissent vivants meurent habituellement dans les soixante-douze heures de la naissance. Dans le but de faciliter le prélèvement des organes de ces nouveaux-nés avant leur décès, d'aucuns ont proposé de les considérer comme « morts à la naissance », « en état de mort cérébrale », « morts-nés », ou de les exclure de quelque autre manière de l'application du critère moderne de la mort[1089]. Pour les raisons exposées dans le présent document, la Commission n'est pas convaincue de l'opportunité de modifier la définition de la mort fondée sur la cessation de l'ensemble des fonctions cérébrales afin de faciliter le prélèvement d'organes sur les nouveau-nés anencéphales. Elle persiste à croire que la définition légale de la mort ne devrait pas être déterminée « par référence seulement ou principalement à la transplantation d'organes »[1090].

V. Prélèvements sur des personnes mortes

Les solutions envisageables pour la réglementation du prélèvement, à des fins thérapeutiques, de tissus et d'organes sur des personnes mortes vont de l'obligation du consentement exprès au prélèvement discrétionnaire effectué sans égard au consentement ou à une opposition. La Commission préconise en ce moment le maintien du régime fondé sur le consentement exprès, pour plusieurs raisons. Premièrement, le cadre technique et éthique décrit plus haut attribue au droit un rôle nécessairement limité dans la recherche de remèdes à la pénurie de tissus et d'organes. Deuxièmement, la Commission estime

1087. Voir la loi uniforme de 1989, précitée, note 833, art. 6, 7.

1088. Voir le texte accompagnant la note 574, *supra*.

1089. Voir *supra*, pp. 112-113.

1090. Voir *supra*, p. 116.

que des réformes modestes visant à remédier à des problèmes bien précis s'avéreront suffisantes, et qu'il n'y a donc pas lieu pour l'heure de recommander des mesures qui s'écarteraient sensiblement du régime actuel. Troisièmement, cette attitude semble également de mise du point de vue des droits de la personne, lequel incite le législateur à porter atteinte le moins possible aux droits en cause dans la poursuite de ses objectifs[1091].

Quatrièmement, si la Commission est d'une manière générale acquise au principe de l'efficacité comme objectif national, elle estime néanmoins qu'il serait très imprudent de ne pas se limiter, sur le plan juridique, à supprimer les ambiguïtés du droit et à appuyer les efforts visant à favoriser les transplantations relevant de la haute technologie médicale. Si, par exemple, on tentait par des moyens législatifs d'accroître radicalement le nombre d'organes disponibles, on risquerait d'escamoter d'importantes priorités concernant la répartition, sur le plan global, des soins de santé. En effet, un tel accroissement serait susceptible d'entraîner une augmentation de la demande à l'égard des transplantations, au détriment d'autres interventions médicales, moins complexes et d'une rentabilité démontrée, qui mériteraient d'être prises en considération[1092]. La Commission et la société ont un urgent besoin d'information additionnelle pour prendre des décisions éclairées sur de tels problèmes. Aussi recommandons-nous avec insistance que des recherches plus approfondies soient faites à ce chapitre.

Enfin, de nombreux spécialistes de la bioéthique consultés par la Commission sont d'avis que des solutions comme la présomption de consentement sont acceptables du point de vue de l'éthique, mais ne jouissent vraisemblablement pas encore d'un appui important dans la société canadienne. Si c'est exact, tout changement marqué par rapport au régime du consentement exprès actuellement en vigueur devrait être précédé de mesures éducatives persistantes et de large portée susceptibles de faciliter l'établissement d'une présomption générale de consentement, celle-ci dût-elle s'avérer nécessaire. La Commission est d'avis que lorsque la société disposera de données sur les résultats des correctifs apportés au régime du consentement exprès et sur la répartition des ressources, elle sera mieux en mesure de décider de l'opportunité d'instaurer un régime fondé sur la présomption de consentement.

A. Régime du consentement exprès — « opting in »

(1) Principe général

RECOMMANDATION

7. (1) Il y aurait lieu de maintenir et de renforcer, à l'égard des prélèvements sur des personnes décédées, le régime du consentement exprès, qui est préférable du point de vue de l'intérêt public.

1091. Voir *supra*, le texte accompagnant la note 893.

1092. Voir *supra*, ch. I, section IV.C.

(2) Il y aurait lieu de respecter légalement la volonté des personnes ayant exprimé le souhait que l'on effectue des prélèvements sur leur cadavre.

C'est le régime prédominant au Canada en ce qui concerne les prélèvements sur des personnes décédées[1093]. D'une part, il encourage le libre consentement et l'altruisme. D'autre part, il permet de tenir compte des convictions religieuses de la famille, et aussi de sa volonté, dans la mesure où elle peut autoriser les prélèvements au nom du défunt dans certaines circonstances. En revanche, des possibilités de prélèvements risquent d'être perdues, à cause des faiblesses particulières de ce régime[1094]. Il existe également une incertitude juridique regrettable sur le point de savoir si la volonté des membres de la famille peut l'emporter sur celle exprimée par le défunt.

(2) Cas spéciaux : donneurs potentiels n'ayant pas exprimé leur volonté, cadavres non réclamés — mécanismes de sensibilisation

RECOMMANDATION

8. (1) Les hôpitaux devraient établir par écrit des protocoles et des lignes de conduite, et envisager l'application de mécanismes de sensibilisation, afin de résoudre le problème des donneurs potentiels n'ayant pas exprimé leur volonté.

(2) Santé et Bien-être social Canada devrait élaborer et diriger un projet pilote dans des hôpitaux désignés relevant de la compétence fédérale, afin de mettre en application des mécanismes de sensibilisation et d'en déterminer les effets.

(3) Santé et Bien-être social Canada devrait encourager les autres hôpitaux et les provinces à participer à ce projet pilote, en mettant des crédits fédéraux à la disposition des autres hôpitaux disposés à mettre en application des mécanismes de sensibilisation et à rendre compte des résultats.

Dans bien des pays, l'application du régime du consentement exprès a suscité d'importantes difficultés. La plupart des donneurs potentiels ne signent pas les cartes autorisant les prélèvements, même si les sondages d'opinion indiquent qu'une grande partie de la population est en faveur du don d'organes et de tissus[1095]. C'est ainsi que trop

1093. Voir *supra*, pp. 154-155.

1094. Comparer pp. 39-41 et 176-182, *supra*.

1095. Voir *supra*, note 225. Voir également pp. 40-41, 157, 176-182, *supra*.

souvent, les hôpitaux se trouvent dans la situation où une personne qui vient de mourir et est considérée comme un donneur potentiel n'a aucunement manifesté sa volonté à l'égard d'éventuels prélèvements[1096].

Pour essayer de remédier à ce problème, il nous semble opportun de proposer des perfectionnements au régime du consentement exprès. Ces perfectionnements, appliqués dans divers pays ces dernières années, consistent dans l'instauration de mécanismes de sensibilisation[1097]. Ils sont fondés sur les textes régissant les dons de tissus qui autorisent la famille du défunt à consentir à des prélèvements au nom de ce dernier. Dans tous les cas, il s'agit essentiellement d'obliger les hôpitaux, d'une part, à établir des protocoles concernant la désignation des donneurs ayant exprimé leur volonté et des donneurs potentiels ne l'ayant pas fait, et, d'autre part, à établir des mécanismes par lesquels les familles des donneurs potentiels sont informées, d'une manière générale, de la possibilité du don de tissus ou se voient offrir l'occasion d'autoriser les prélèvements. Nous utilisons ici l'expression « mécanismes de sensibilisation » pour décrire les dispositions ou les lignes de conduite qui présentent ces deux caractéristiques. On a retenu des variantes de cette solution en Australie et en Grande-Bretagne, ainsi qu'aux États-Unis (droit fédéral, lois « uniformes » et législation de la plupart des États)[1098].

Une fois reconnu l'intérêt de la solution en question, il reste à savoir de quelle manière elle peut être mise en œuvre. Les hôpitaux ou les professionnels de la santé devraient-ils être tenus, d'une manière générale ou même en vertu de la loi, de désigner les donneurs potentiels et de sonder la famille ? Comme il ne nous paraît pas nécessaire, pour le moment, d'adopter un texte législatif d'application nationale au sujet des prélèvements, ainsi que cela a été fait aux États-Unis[1099], la question peut être laissée aux provinces. La Commission juge tout de même bon de faire connaître son analyse, vu les dimensions nationales et internationales que tendent à prendre les régimes de prélèvement, le petit nombre d'hôpitaux fédéraux concernés par la question et les discussions en cours à l'échelon provincial.

Ceux qui s'opposent à ce que la loi oblige les médecins à s'adresser à la famille font habituellement valoir les arguments suivants : (1) une telle obligation serait une ingérence injustifiée dans les prérogatives professionnelles et la vie privée des familles ; (2) le législateur chercherait ainsi à régler non pas un problème d'ordre juridique, mais un problème d'ordre administratif et éducatif ; (3) cela entraînerait une augmentation des coûts pour les hôpitaux et le système des soins de santé ; (4) les manquements à cette obligation pourraient entraîner des sanctions ou des poursuites.

Les partisans de l'approche législative, par contre, invoquent les arguments suivants : (1) la pénurie de tissus est principalement imputable au fait qu'on se refuse à aborder les familles des donneurs potentiels n'ayant pas exprimé leur volonté, même si tout indique

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1096. Voir *supra*, pp. 40-41.

1097. Voir *supra*, pp. 157-158, 176-182 et *infra*, pp. 227-228.

1098. Voir *supra*, note 925 et pp. 176-182.

1099. Voir *supra*, note 995.

que dans la plupart des cas elles ne s'opposeraient aucunement à ce qu'on leur donne l'occasion, dans de telles circonstances, de consentir à des prélèvements, cette démarche s'inscrivant dans le processus du deuil[1100] ; (2) le fait d'imposer aux hôpitaux une telle obligation entraînerait vraisemblablement une hausse du nombre de prélèvements ; (3) on pourrait formuler cette obligation légale de manière à permettre l'exercice du jugement professionnel et la prise en considération des circonstances. Il conviendrait en effet de laisser aux professionnels toute latitude pour ne pas présenter la demande de consentement dans les cas où cela causerait manifestement un préjudice démesuré, ou serait inopportun pour quelque autre raison.

À la lumière de ces considérations, trois raisons nous convainquent que la solution des mécanismes de sensibilisation décrite ci-dessus mérite d'être examinée dans le contexte canadien. Premièrement, elle semble favoriser l'éducation du public et des professionnels, ainsi qu'une réforme centrée d'une façon particulière sur un aspect essentiel qui, pour tous les analystes canadiens, constitue un obstacle à l'augmentation du nombre de prélèvements[1101]. En effet, le difficile n'est pas tant, semble-t-il, de susciter l'altruisme que de fournir aux patients et à leur famille l'occasion concrète de donner suite à leurs bonnes intentions. Deuxièmement, elle se distingue du prélèvement obligatoire et de la vente de tissus humains sous deux aspects importants : elle favorise la pratique de l'altruisme et le libre consentement. Troisièmement, elle semble moins apte à provoquer des contestations judiciaires pour atteinte à la liberté de religion, à l'autonomie de l'individu et à l'intimité de la vie privée. En encourageant le libre consentement et en permettant la prise en considération directe des volontés de la famille, en outre, elle est vraisemblablement moins susceptible de porter atteinte aux droits fondamentaux de la personne, constitutionnellement garantis ou non. Tout cela incite à conclure que la solution reposant sur l'instauration de mécanismes de sensibilisation est la plus indiquée, pour les cas où le donneur potentiel n'a pas fait connaître ses volontés.

Mais la meilleure solution ne comporte pas nécessairement une garantie de résultats. Il y a une certaine controverse sur la question de savoir s'il est opportun que le législateur impose une telle obligation aux professionnels de la santé ou, d'une manière plus générale, aux hôpitaux. Chose certaine, les chirurgiens, les coordonnateurs des transplantations, les neurologues, les infirmiers et infirmières, les aumôniers des hôpitaux joueraient tous un rôle essentiel dans la mise en œuvre d'un tel régime. Un bon nombre de professionnels de la santé estiment sans doute déjà qu'il est de leur devoir, éthique et professionnel, de sonder la famille. Pourtant, leur répugnance ou leur réticence à le faire pourrait influer sur le succès ou l'échec de cette solution. Personne ne devrait être contraint à demander à autrui de consentir à des prélèvements. Mais d'autre part, il n'est pas non plus dans l'intérêt public que des organes soient perdus simplement parce que le patient ou la famille n'a pas pensé, au moment critique, à la possibilité de consentir à des prélèvements utiles.

Des considérations d'ordre pratique contribuent sans doute, toutefois, à atténuer ces préoccupations. Puisque de nombreux donneurs potentiels n'ayant pas exprimé leur volonté

1100. Voir *supra*, note 985.

1101. Voir *supra*, pp. 40-41.

meurent à l'hôpital, il semblerait opportun d'imposer à celui-ci l'obligation de sonder la famille, comme l'a suggéré l'Association du Barreau canadien (voir annexe A). Cela permettrait sans doute aussi à l'hôpital de faire preuve d'imagination sur le plan administratif en déléguant cette obligation à des professionnels, qui s'en acquitteraient avec tact, efficacité et à peu de frais.

Santé et Bien-être social Canada pourrait contribuer à l'évaluation des effets des mécanismes mis sur pied par les hôpitaux, en élaborant et en coordonnant un programme pilote, conforme aux principes de la méthodologie, à l'intention de certains hôpitaux de compétence fédérale. En mettant des crédits à la disposition des hôpitaux désireux de se lancer dans des projets pilotes axés sur l'instauration et l'application de mécanismes de sensibilisation, le Ministère pourrait également encourager la participation d'autres hôpitaux. Les données fournies par les hôpitaux participants pourront aider la société à apprécier les avantages des perfectionnements apportés au régime du consentement exprès.

Dans cette perspective, le protocole présenté ci-dessous pourrait s'avérer utile face au problème des donneurs potentiels n'ayant pas exprimé leur volonté. Il s'inspire des recommandations de la Commission de réforme du droit de l'Australie, qui ont été retenues dans la plupart des États australiens[1102].

(1) Les hôpitaux devraient établir par écrit des protocoles et des marches à suivre visant à la désignation des donneurs potentiels, et portant notamment sur la formation des professionnels ;

(2) Les hôpitaux dotés de tels protocoles devraient, d'une manière générale, avoir le pouvoir d'effectuer des prélèvements sur les donneurs potentiels n'ayant pas exprimé leur volonté, une fois que l'on s'est acquitté de deux obligations. Il faut faire de bonne foi des efforts diligents :

a) pour vérifier s'il existe des documents indiquant que le défunt avait consenti à des prélèvements sur son cadavre ;

et, si l'on n'en trouve aucun,

b) communiquer avec les membres de la famille et leur donner l'occasion de consentir aux prélèvements, en les informant de cette possibilité. Le non-consentement de la famille serait, en droit, déterminant. Les efforts en vue de retracer les membres de la famille et de communiquer avec eux, directement ou par l'intermédiaire des autorités publiques, devraient être poursuivis durant un temps raisonnable (par exemple, quarante-huit heures, ou le délai que justifie le temps de survie raisonnable des tissus en cause). Les personnes chargées d'établir le diagnostic de mort cérébrale ou de désigner les donneurs potentiels ne devraient pas participer à ces tentatives.

(3) Lorsque, malgré des efforts diligents faits de bonne foi, on ne réussi pas à retracer la famille ou à communiquer avec elle, aucun prélèvement ne devrait être effectué.

1102. Voir *supra*, pp. 182-183.

Certaines précisions sont de mise au sujet du paragraphe (3) de ce protocole, relatif aux prélèvements sur des donneurs potentiels n'ayant pas exprimé leur volonté et dont on ne parvient à retracer aucun parent sur le moment. L'exclusion de tout prélèvement dans de tels cas est fondée sur le principe du consentement exprès. Or, certains analystes préconisent plutôt, à ce sujet, l'application d'une présomption restreinte de consentement, et certains États ont adopté des dispositions en ce sens. Les législations australienne et américaine autorisent, dans des circonstances restreintes, les prélèvements sur des donneurs potentiels n'ayant pas exprimé leur volonté, quand on n'a pu retracer aucun parent[1103]. La *Loi uniforme sur les dons de tissus humains* (1989) de la Conférence sur l'uniformisation des lois au Canada semble également comporter une présomption de consentement limitée à l'égard des prélèvements sur des donneurs potentiels confiés à un médecin légiste[1104]. Cette règle n'est pas sans précédent historique au Canada où, dès le XIX^e^ siècle, les cadavres non réclamés étaient en vertu des lois provinciales sur l'anatomie offerts en premier lieu aux facultés de médecine[1105].

B. Présomption de consentement — « opting out »

Suivant la théorie de la présomption de consentement, la société peut raisonnablement présumer l'existence d'un consentement aux prélèvements effectués après la mort, à moins qu'il y ait des indices d'une opposition. Cette présomption, comme le régime du consentement exprès, est centrée sur la volonté du défunt, et elle s'accorde davantage avec les notions d'altruisme que le prélèvement obligatoire. On la tient pour raisonnable au nom de l'altruisme de la collectivité, et elle est justifiée au surplus par le fait que l'accroissement potentiel du nombre d'organes et de tissus disponibles contribue à sauver des vies. On pense aussi que les demandes de consentement présentées d'une façon brutale peuvent exacerber la douleur de la famille, et que la présomption permet d'éviter cet écueil.

En revanche, plusieurs arguments semblent militer contre l'application immédiate et systématique de la présomption de consentement. Premièrement, les données recueillies en France et dans d'autres pays européens ayant retenu cette solution portent à conclure qu'elle n'entraîne pas toujours un accroissement des prélèvements[1106]. Deuxièmement, les objectifs auxquels répond la présomption de consentement peuvent être contrecarrés par les difficultés pratiques que suscite la nécessité de déterminer si le défunt avait manifesté son opposition aux prélèvements, ainsi que par les implications cliniques et psychologiques des rapports avec la mort et avec la famille éprouvée[1107]. Les textes adoptés dans les pays de l'Europe de l'Ouest ayant établi une présomption de consentement diffèrent en ce qui a trait au rôle accordé à la famille dans la recherche de la volonté du défunt[1108]. Malgré

1103. Voir *supra*, ch. IV.

1104. Voir *supra*, note 837.

1105. Voir *supra*, pp. 2-3, 148-150.

1106. Voir *supra*, pp. 169-176.

1107. *Ibid.*

1108. Voir *supra*, pp. 169-176 et 190.

la lettre de la loi, on consulte en pratique la famille dans la plupart des cas, ce qui semble remettre en question l'utilité d'une présomption de consentement rigoureuse. Troisièmement, certaines lois américaines établissant une présomption de consentement ont été contestées au motif qu'elles porteraient atteinte aux droits fondamentaux de la personne[1109]. Enfin, la présomption de consentement est susceptible de nuire à la communication entre le médecin, le patient et la famille, à un moment où le dialogue et la compréhension prennent une importance toute particulière. Dans la mesure où l'on peut échapper à ces possibles inconvénients en ayant recours à d'autres solutions tout aussi efficaces sur le plan thérapeutique, la présomption de consentement paraît moins intéressante[1110]. Cela nous amène à conclure qu'il n'y a pas lieu d'étendre la portée des dispositions qui établissent déjà une certaine présomption de consentement au Canada[1111]. Nous pensons que la valeur relative d'une présomption de consentement systématique pourra mieux être appréciée lorsqu'on disposera de données sur les effets de la solution fondée sur les mécanismes de sensibilisation.

C. Consentement non requis — prélèvement discrétionnaire

Au regard de différentes conceptions de l'autonomie, le prélèvement discrétionnaire de tissus et d'organes sur des donneurs décédés, effectué sans tenir compte de la volonté qu'ils auraient pu exprimer de leur vivant, pourrait heurter deux principes éthiques : autonomie du donneur potentiel vivant, respect à l'égard des morts. Cette approche semble également plus susceptible de porter atteinte aux croyances et aux pratiques religieuses et d'exclure la prise en compte des préoccupations légitimes de la famille. Le prélèvement discrétionnaire irait par ailleurs directement à l'encontre de la politique actuellement appliquée au Canada à l'égard des prélèvements sur des personnes mortes. La Commission ne souscrit pas à cette solution, comme en témoigne son appui au régime du consentement exprès[1112].

D. Respect à l'égard des morts

RECOMMANDATION

9. (1) L'article 182 du *Code criminel* devrait être remplacé par une disposition incriminant le fait de manquer de respect à l'égard d'un cadavre humain ou de restes humains.

(2) Le Rapport n° 31 de la Commission devrait être modifié par l'adjonction, aux crimes contre l'ordre public proposés (chapitre 22), de la disposition suivante :

1109. Voir *supra*, pp. 160-165.

1110. Voir *supra*, le texte accompagnant la note 893.

1111. Voir *supra*, le texte accompagnant les notes 845 à 848.

1112. Conformément à la COMMISSION MANITOBAINE DE RÉFORME DU DROIT, *op. cit.*, note 157, pp. 30-31.

Manque de respect à l'égard d'un cadavre. Commet un crime quiconque, à dessein ou par témérité, manque de respect à l'égard d'un cadavre humain ou de restes humains.

L'obligation de respect à l'égard du cadavre est l'obligation de ne pas porter atteinte à sa dignité et à son caractère humain intrinsèques. Elle comporte aussi l'obligation de tenir compte des attentes de la famille, ainsi que de ses sentiments moraux et religieux. À la limite, le manque de respect à l'égard du cadavre peut heurter des convictions morales partagées par la collectivité. L'utilisation médicale, non autorisée par la famille, d'un patient qui vient de mourir ou qui est en état de mort cérébrale et est branché à un respirateur, peut n'entraîner aucune défiguration, aucune mutilation, ni porter sérieusement atteinte à l'intégrité physique du corps. Elle est malgré cela susceptible de blesser les proches parents, dans la mesure où se trouve battue en brèche la relation de confiance si importante pour les médecins, les patients, les familles et les hôpitaux[1113].

Dans le contexte du droit pénal, il paraît important que la disposition centenaire du *Code criminel* relative aux crimes contre les cadavres — l'article 182 — soit cohérente et claire. Elle concerne à la fois le devoir d'inhumer les morts et les actes irrespectueux envers les cadavres. Dans son rapport n° 31, la Commission a qualifié cette disposition générale d'archaïque. En effet, comme de nos jours l'inhumation des cadavres est régie par des lois provinciales, l'alinéa 182*a*) du *Code criminel*, consacré à cette question, n'est plus nécessaire[1114].

Il n'en va pas de même en ce qui concerne l'alinéa 182*b*), relatif aux actes irrespectueux à l'égard de cadavres. La plupart des textes provinciaux sur l'inhumation ne concernent que la conduite dans les cimetières, tandis que les dispositions consacrées aux infractions d'ordre sexuel concernent, pour la plupart, des cas où la victime est vivante. Par conséquent, ni ces dispositions ni aucune infraction criminelle proposée ne visent clairement ou suffisamment la mutilation illégale et intentionnelle de cadavres humains, les actes sexuels à leur égard, ni d'une manière générale le manque de respect illégal envers eux. Or à notre avis, de tels actes causent des préjudices universels assimilables à des crimes contre l'humanité, relativement à la dignité du défunt et de la société tout à la fois. Les codes criminels anciens comme les codes plus récents, des textes en vigueur dans des pays comme la France, l'Australie, les États-Unis et la Nouvelle-Zélande, expriment la condamnation sociale de tels actes par des sanctions pénales[1115]. Les termes utilisés dans le texte ici proposé, fondé sur la disposition du *Model Penal Code* américain, sont suffisamment larges pour viser toute une gamme d'infractions[1116]. Suivant le paragraphe 3(13) des recommandations faites dans le rapport n° 31, qui met à l'abri de la responsabilité pénale les personnes agissant en vertu de la loi, l'infraction ne pourrait être imputée à l'égard d'interventions légales sur les cadavres (autopsies, transplantations d'organes, embaumement, etc.).

1113. Voir *supra*, pp. 131-136.

1114. Voir *supra*, pp. 126-131, particulièrement la note 698.

1115. Voir *ibid.*, particulièrement les notes 676 et 696.

1116. Voir *supra*, pp. 126-131, particulièrement les notes 692 et 696.

VI. Considération générales

A. Innocuité des techniques de remplacement des tissus humains

RECOMMANDATION

10. (1) Il y aurait lieu d'établir clairement par des dispositions législatives que les dispositions de la *Loi sur les aliments et drogues* fédérale consacrées à la « protection des patients » s'appliquent à toutes les techniques de remplacement de tissus humains, de façon que celles-ci soient soumises à des normes de sécurité nationales minimales et uniformes.

(2) Par conséquent, la *Loi sur les aliments et drogues* devrait être modifiée par l'adjonction d'une nouvelle partie consacrée à la réglementation des techniques de remplacement de tissus humains, définies de façon large.

Les progrès des sciences biomédicales et biotechnologiques modernes ont commencé à brouiller la distinction entre certains tissus thérapeutiques humains, substances humaines et produits dérivés de tissus humains utilisés dans les divers régimes. À mesure que s'accentue la tendance à utiliser des tissus transformés, biosynthétiques et bioprosthétiques, les ambiguïtés des dispositions législatives régissant ces régimes deviennent plus accusées. Suivant le droit actuel, il n'est pas toujours possible de savoir avec certitude si certains tissus, substances corporelles et techniques biosynthétiques de remplacement des tissus — cryogénisation et implant de lentilles oculaires, bioprothèses cardiaques, moelle osseuse ou sperme traités et conservés, etc. — sont visés par les mêmes normes nationales minimales que d'autres techniques de remplacement concernant des tissus comme le plasma sanguin et les lentilles intraoculaires[1117]. Étant donné que la *Loi sur les aliments et drogues* s'applique également aux produits importés au Canada, l'adoption de dispositions énonçant clairement que les techniques thérapeutiques de remplacement de tissus humains sont régies par ce texte améliorerait la protection nationale et internationale[1118].

Les modifications législatives proposées mettraient fin à ces ambiguïtés. Une autre solution consisterait à modifier la *Loi sur les aliments et drogues* afin de conférer à Santé et Bien-être social Canada le pouvoir d'assimiler, par des textes réglementaires, un tissu humain à un médicament biologique, un instrument médical ou un implant. Comme cette solution consisterait essentiellement à soumettre à la réglementation actuelle certaines techniques de remplacement de tissus, elle risque de ne pas permettre une latitude législative suffisante pour la réglementation des techniques en préparation et futures. Aussi la Commission préconise-t-elle l'adjonction à la *Loi sur les aliments et drogues* d'une partie consacrée aux techniques de remplacement de tissus, de façon que Santé et Bien-être Canada dispose d'un pouvoir étendu et exprès correspondant à celui qui lui est conféré pour la réglementation des médicaments, des instruments médicaux et des cosmétiques.

1117. Voir *supra*, pp. 137-142.

1118. Voir *ibid.*, particulièrement la note 761.

B. Réglementation ou interdiction de la vente

RECOMMANDATION

11. (1) Il y aurait lieu d'établir une infraction au *Code criminel* à l'égard de l'achat et de la vente de cadavres humains, d'organes humains ou d'autres tissus humains non susceptibles de régénération.

(2) Dans la détermination de la portée de cette disposition, le législateur devrait exclure de la définition du terme « vente » le remboursement des frais raisonnables de déplacement ou d'hébergement engagés par le donneur, les pertes de salaire raisonnables subies par lui, ainsi que les paiements raisonnables liés au prélèvement, au transport, au traitement, à la conservation et à l'utilisation thérapeutique des tissus.

Ceux qui s'opposent à la vente des tissus invoquent d'ordinaire deux arguments d'ordre éthique et deux voies de réglementation. Selon le point de vue « formaliste », la vente est en soi condamnable du point de vue moral, et doit donc impérativement être interdite. Selon le point de vue « utilitariste », en revanche, il peut s'avérer opportun de l'interdire après avoir soupesé l'importance relative des conséquences bonnes ou néfastes, mais on admet la possibilité d'une autorisation. En fait, le véritable « utilitariste » souscrira à la non-interdiction si les bienfaits probables de la vente l'emportent sur les inconvénients vraisemblables, ou si le risque d'inconvénients est jugé insuffisant pour justifier l'interdiction législative. Par exemple, les lois provinciales sur les prélèvements adoptées au cours des deux dernières décennies sont dans l'ensemble davantage axées sur le point de vue « utilitariste », dans la mesure où l'on a choisi d'interdire la vente des tissus non susceptibles de régénération[1119].

L'achat et la vente de cadavres humains, d'organes et de tissus non susceptibles de régénération peuvent donc être interdits tant du point de vue formaliste que du point de vue utilitariste. Suivant la thèse formaliste, la vente de cadavres est contraire à des principes moraux, bien ancrés dans la collectivité, concernant le respect à l'égard des morts, à l'égard d'un être humain décédé. C'est le fondement historique de l'article 182 du *Code criminel*. La vente d'un corps humain vivant viole le droit intrinsèque et inaliénable de tout être humain de ne pas être traité comme une marchandise. Cette idée est actuellement exprimée dans les loi provinciales sur l'adoption. La vente d'organes humains heurte elle aussi la dignité humaine, comme le font valoir les nombreuses personnes qui manifestent leur inquiétude devant la perspective de voir le corps humain considéré comme une simple marchandise.

Le versement d'argent en contrepartie d'organes et de cadavres humains soulève également des inquiétudes légitimes du point de vue utilitariste. Par exemple, les incitations financières pourraient amener des gens à mettre en péril leur santé et leur sécurité en s'exposant à des risques physiques exagérés. Autre crainte, celle de voir l'attribution des

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1119. Voir *supra*, pp. 151-158, particulièrement les notes 843 et 856.

tissus être déterminée selon la capacité de payer, ce qui risquerait de faire passer au second plan des critères plus importants, tel celui des besoins médicaux[1120]. Ces préoccupations d'ordre formaliste et utilitariste valent peut-être pour la vente de tissus et de substances susceptibles de régénération, mais c'est avant tout au sujet des cadavres, des organes et des tissus non susceptibles de régénération qu'elle acquièrent tout leur poids, toute leur portée[1121].

Ces divers arguments ont une incidence directe sur la question de savoir s'il y a lieu d'interdire expressément les ventes d'organes humains au moyen d'une disposition du *Code criminel*. Pour apprécier d'une manière générale l'opportunité de créer une infraction criminelle, la Commission a établi quatre critères[1122]. Pour le problème qui nous intéresse ici, ils se présentent sous la forme suivante. (1) La vente d'organes cause-t-elle un préjudice sérieux ? (2) Ou contrevient-elle sérieusement à des valeurs fondamentales ? (3) Dans l'affirmative, l'adoption de mesures à l'encontre de tels actes porterait-elle atteinte à des valeurs fondamentales ? (4) Le droit pénal contribuerait-il de façon importante à la solution du problème ?

L'application de ces critères au cas traité ici fait ressortir que l'opportunité de créer une infraction criminelle tient dans une large mesure à la question de savoir si le droit criminel est susceptible de contribuer sensiblement à éliminer les maux associés à la vente d'organes. En ce qui a trait au préjudice causé à autrui, le versement d'argent pourrait inciter certaines personnes à prendre des risques physiques injustifiés, amener les vendeurs à cacher des éléments de leur dossier médical (relatifs à une maladie transmissible ou d'ordre génétique) susceptibles de constituer une menace pour le receveur, par crainte qu'on refuse de payer pour des tissus malades ou présentant quelque anomalie ; à l'extrême, les fortes sommes offertes pour certains organes pourraient pousser au meurtre[1123]. Par ailleurs, si l'altruisme est considéré comme une valeur fondamentale, la vente d'organes risque de battre en brèche le principe éthique du « don de la vie ». On pourrait faire valoir aussi qu'elle porte atteinte à la dignité humaine dans la mesure où elle équivaut à exploiter la misère économique et médicale, et réduit à de simples marchandises le corps humain et ses éléments constitutifs — tout cela influant sur notre conception du corps et de la personne, sur la valeur que nous leur attribuons[1124]. L'application d'une disposition sur la vente d'organes ne constituerait pas une atteinte à la liberté personnelle ni à la vie privée, à moins que, par une interprétation large, on soit amené à conclure que celles-ci comprennent

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1120. Voir *supra*, pp. 95-97.

1121. Si, par suite des progrès de la technologie médicale, il est devenu plus difficile d'établir dans certains cas une distinction entre les tissus et organes susceptibles de régénération et ceux qui ne le sont pas, cette distinction s'avère néanmoins toujours utile pour établir des catégories concernant la nature générale des risques physiques, l'atteinte à l'intégrité corporelle et l'irréversibilité, s'agissant des prélèvements et des transplantations. Voir *supra*, note 85 et pp. 23-24.

1122. Voir Rapport n° 3, *op. cit.*, note 730, pp. 33-34. Voir également CRD, *Les crimes contre le fœtus*, Document de travail n° 58, Ottawa, la Commission, 1989, p. 33.

1123. Voir D.W. Roughead, *op. cit.*, note 664 et le texte l'accompagnant.

1124. Voir *supra*, pp. 62-70, 90-99.

le droit d'aliéner, contre de l'argent, des parties vitales du corps humain. Son application risquerait alors d'avoir un impact disproportionné sur les personnes économiquement défavorisées et susceptibles de vouloir améliorer leur sort par la vente de parties de leurs corps. Par ailleurs, l'établissement d'une telle disposition n'aurait vraisemblablement pas pour effet de diminuer la valeur attribuée à l'objectif de sauver des vies, puisque d'autres solutions, préférables du point de vue de l'éthique, peuvent accroître la quantité de tissus humains thérapeutiques.

La création d'une infraction criminelle contribuerait-elle de façon importante à résoudre les problèmes associés à la vente d'organes ? Certains feront valoir que le droit pénal est un instrument trop radical pour ce genre de problèmes, que la réglementation est un moyen plus adéquat en l'occurrence, ou que la vente est déjà interdite en vertu de la plupart des lois provinciales. En revanche, d'autres estimeront que le préjudice moral causé aux valeurs fondamentales — dignité humaine, altruisme —, le risque de préjudices physiques ainsi que la protection des personnes justifient sans réserve le recours à l'effet dissuasif du droit pénal, à l'opprobre de la condamnation criminelle. Selon les tenants de cette thèse, l'existence d'une telle infraction établirait une responsabilité pénale minimale uniforme sur l'ensemble du territoire canadien en ce qui a trait aux échanges interprovinciaux de tissus, de plus en plus nombreux, et aurait un effet dans les provinces où la vente n'est pas interdite, ou encore l'est de façon imparfaite. En présentant notre recommandation sur l'interdiction de la vente, nous tenons compte du fait que les provinces étudient sérieusement la possibilité d'adopter la nouvelle *Loi uniforme sur le don de tissus humains* proposée en 1989[1125]. Dans le cadre des délibérations nationales sur la réforme des lois relatives aux prélèvements de tissus humains, il faut s'intéresser tout particulièrement à la portée et à la définition des interdictions de vente figurant dans des lois existantes et des lois proposées, ainsi qu'aux solutions retenues dans des dispositions législatives récemment adoptées aux États-Unis, en Grande-Bretagne, en Australie et en Europe[1126].

Enfin, le fait d'interdire la vente par des dispositions pénales est sans doute indiqué au regard de l'évolution de la situation sur le plan international[1127]. On a récemment signalé une recrudescence des inquiétudes au sein de la communauté internationale en ce qui a trait aux ventes d'organes nord-sud ou est-ouest[1128]. L'établissement d'une interdiction dans le *Code criminel* répondrait aux appels récents et répétés lancés par la communauté internationale et l'Organisation mondiale de la santé pour la lutte contre le trafic d'organes, appels dans lesquels le Canada a du reste joué un rôle clé[1129].

C'est pourquoi notre recommandation donne effet aux principes de la gratuité et de l'inviolabilité du corps humain. Nous avons rejeté les propositions visant à établir des

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1125. Voir, *supra*, le texte accompagnant les notes 853 à 857.

1126. Voir *supra*, ch. IV.

1127. Voir *supra*, pp. 186-187.

1128. *Ibid.*

1129. Voir *supra*, pp. 186-189.

marchés d'organes, les jugeant prématurées et directement contraires à l'altruisme. Les lacunes de l'altruisme, en effet, n'obligent pas la société à adhérer à la commercialisation des organes. Il est possible de favoriser l'accroissement de l'offre, et d'ainsi promouvoir la valeur de la vie humaine, en ayant recours à des mécanismes davantage conformes aux principes fondamentaux auxquels adhère la collectivité canadienne. Afin d'éviter que le remboursement des frais légitimes associés aux prélèvements ne soit pas visé par l'interdiction, la recommandation précise que la définition du mot « vente » exclut le remboursement des frais liés au transport, au traitement, à la conservation, etc. On veille aussi, par ce moyen, à ce que le remboursement des frais raisonnables supportés par le donneur ne soit pas puni. De cette manière, l'exercice de l'altruisme par les donneurs n'entraînerait pour eux ni perte ni gain financiers[1130].

C. Droit de propriété et vol

RECOMMANDATION

12. Il y aurait lieu de considérer comme des biens visés par les dispositions du droit pénal relatives au vol les restes humains ou les substances corporelles humaines qui sont en la possession légitime d'une personne ou qu'une personne s'est légalement procurés et a transformés, par son savoir-faire et son travail, en spécimens anatomiques, tissus traités et conservés, pièces de musée, etc.

Notre recherche a mis en lumière une ambiguïté notable qui n'a pas été supprimée par l'adoption, il y a une centaine d'années, de la disposition du *Code criminel* relative au manque de respect à l'endroit des cadavres. Le fondement historique de l'infraction donne à penser que les restes humains qu'on s'est procurés légalement et dont, par son savoir-faire et son travail, on a fait des momies exposées dans des musées, des spécimens anatomiques ou des tissus humains traités et conservés, ne sont peut-être pas protégés par les dispositions du droit pénal relatives au vol, étant donné la répugnance de la common law à considérer les cadavres comme des choses susceptibles d'appropriation[1131]. Cette répugnance porte à croire qu'on peut être poursuivi pour le vol d'un linceul, mais pas de la dépouille qu'il recouvre ; pour le vol du fil qui maintient en place les parties d'un squelette, mais pas du squelette lui-même ; pour le vol des fioles ou des éprouvettes qui contiennent des tissus ou des substances corporelles, mais pas des tissus ou des substances en question[1132]. Cette situation a été critiquée[1133] ; elle semble à la fois anormale et contraire aux principes fondamentaux du droit pénal et à la notion de propriété ayant cours de nos jours. Car suivant l'analyse juridique moderne, qui dit « propriété » ne dit pas nécessairement « commerce ». La Commission est donc d'avis que les valeurs qui sous-tendent le droit pénal seront mieux respectées par la suppression de cette vieille ambiguïté.

1130. Voir *supra*, pp. 97-99.

1131. Voir *supra*, pp. 76-81, 126-131 et particulièrement la note 701.

1132. *Ibid.*

1133. *Ibid.*, particulièrement la note 701.

RECOMMANDATION

13. (1) Lorsque des professionnels de la santé, des hôpitaux ou des chercheurs acquièrent un intérêt commercial dans les tissus ou les cellules d'un patient, ou lorsque l'existence d'un tel intérêt est raisonnablement prévisible, ils devraient être tenus d'en informer le patient.

(2) Lorsqu'il devient raisonnablement clair que l'existence d'un tel intérêt commercial risque d'empêcher le professionnel de la santé d'exercer son jugement professionnel en tenant compte uniquement du bien de son patient, ce professionnel devrait être tenu de confier ce dernier à un confrère ou à une consœur.

(3) Lorsque le professionnel de la santé a informé son patient d'un tel intérêt commercial, on devrait donner au patient l'occasion de refuser la poursuite de son concours ou la continuation du traitement ; et dans le cas d'un tel refus, le professionnel de la santé devrait être tenu de confier le patient à un confrère ou à une consœur.

À l'heure actuelle, il est impossible de savoir d'une manière certaine si la réforme de la *Loi sur les brevets*, l'élaboration de lignes directrices plus explicites en matière de recherche médicale, ou la simple extension des principes de common law, permettraient de répondre à certaines des nouvelles énigmes suscitées par les progrès de la biotechnologie[1134]. Comment la société peut-elle, à la fois, protéger l'intégrité corporelle, l'autonomie et la dignité des sources de tissus humains — les patients, notamment - -, tout en encourageant et en protégeant le génie créateur des spécialistes de la biotechnologie qui mettent au point des produits thérapeutiques potentiellement lucratifs dont le public peut profiter ? Vu les progrès réalisés, la maxime « la loi ne s'occupe pas des choses sans importance » ne paraît plus applicable à l'égard de tissus ou de substances, prélevés sur le corps humain, que l'on a longtemps jugé dénués de quelque valeur[1135].

D'aucuns ont soutenu que la reconnaissance d'un droit de propriété restreint — et non pas d'intérêts commerciaux — pourra protéger les patients contre les atteintes à leur intégrité corporelle ou l'exploitation commerciale, sans leur consentement, de tissus prélevés sur eux[1136]. Il reste à savoir si cela aidera à préciser les droits des donneurs et les devoirs correspondants des professionnels de la santé, à l'égard des substances humaines.

D'ici là, certains principes traditionnels du droit médical peuvent nous guider. Lorsqu'un médecin, un hôpital ou un chercheur a un intérêt commercial dans les cellules ou les tissus d'un patient, ou que l'apparition d'un tel intérêt est raisonnablement prévisible, le patient devrait vraisemblablement en être informé, suivant les principes touchant le consentement éclairé. Le critère de la prévisibilité est un critère objectif. Cette obligation

1134. Voir *supra*, pp. 36-37, 84-90 et 143.

1135. Voir *supra*, p. 87.

1136. Voir *supra*, pp. 76-90.

d'information est renforcée par le devoir de loyauté, de confiance et de bonne foi que le médecin a envers son patient. Lorsque le médecin a un intérêt commercial ou autre qui risque d'être incompatible avec son obligation d'exercer son jugement professionnel en toute impartialité et de n'agir qu'en fonction du bien du patient, il devrait être tenu d'une manière générale d'expliquer à son patient les tenants et les aboutissants de la situation. Il serait alors loisible au patient de consentir à la poursuite du traitement ou de décider de continuer à prêter son concours. Dans le cas où il refuserait de donner ce consentement, ou s'il s'avérait raisonnablement clair que le conflit d'intérêts nuit à la capacité du médecin d'administrer un traitement désintéressé et professionnel, ce dernier serait tenu de confier son patient à quelqu'un d'autre. La surveillance exercée par les comités de recherche et d'éthique formés dans les hôpitaux pourrait également réduire les risques d'abus.

Les principes énoncés ci-dessus peuvent sans doute limiter les possibilités de conflits entre patients et médecins, lorsque les seconds, à partir de tissus des premiers, mettent au point des substances susceptibles d'exploitation commerciale. Peut-être toutefois ne rendent-ils pas compte de la complexité des intérêts en jeu et des problèmes qui se posent. Des recherches plus poussées s'imposent donc dans ce domaine en pleine évolution, comme nous le précisons ci-après.

D. Mesures d'incitation fiscales ?

RECOMMANDATION

14. Pour l'instant, le législateur devrait s'abstenir de permettre, par des modifications à la *Loi de l'impôt sur le revenu*, des déductions ou des crédits fiscaux pour le don de tissus ou d'organes.

Y aurait-il lieu de donner au concept de don, d'intention charitable, un effet pratique ou financier par le truchement du droit fiscal ? Si des dispositions législatives ont été proposées à l'étranger pour permettre les déductions ou les crédits fiscaux pour le don de tissus ou d'organes à des fins thérapeutiques, elles n'ont à notre connaissance jamais été adoptées[1137]. On ne sait pas vraiment si cet encouragement ferait augmenter le nombre de dons de tissus disponibles, mais il est probable que de telles déductions favoriseraient surtout les contribuables à revenu élevé. Dans le cadre des régimes actuellement en vigueur, en outre, de telles règles fiscales risqueraient de donner une valeur pécuniaire aux tissus naturels, et de laisser croire qu'un prix peut leur être attribué, comme à tout autre bien[1138]. Or, tout cela constitue une menace pour la notion d'altruisme sur laquelle reposent ces régimes publics.

1137. Voir *supra*, note 800.

1138. Voir I. KANT, *op. cit.*, note 352 et l'extrait cité.

VII. Questions sur lesquelles des recherches s'imposent

Le domaine en pleine évolution des prélèvements et des techniques de remplacement des tissus humains suscite un certain nombre de questions connexes d'intérêt national qui méritent une réflexion plus approfondie : attribution de ressources insuffisantes et listes d'attente pour des transplantations ; prélèvement, transformation et commercialisation de cellules et de tissus humains ; prélèvement de tissus fœtaux ; échanges internationaux de tissus et d'organes ; situation, sur le plan éthique, des patients en état de mort cérébrale.

A. Attribution de ressources insuffisantes[1139]

Quel est l'investissement optimal de la société en matière de transplantation de tissus et d'organes, en matière de soins primaires et préventifs ? En vue de faire progresser le débat public et éthique sur de telles questions, des recherches s'imposent sur la rentabilité des techniques de transplantation, dans le cadre d'un effort global visant à soumettre la médecine de haute technologie à une évaluation critique permanente. Le temps est peut-être venu, du reste, de faire de la rentabilité un critère national, s'agissant de l'engagement inscrit dans la *Loi sur la santé* canadienne quant à la nécessité d'assurer aux Canadiens les services de santé « médicalement nécessaires »[1140]. L'initiative fédérale-provinciale qui a abouti récemment à la formation de l'Office canadien de coordination de l'évaluation des technologies de la santé (OCCETS) est un pas opportun et digne de mention dans cette direction. Les techniques de remplacement des tissus et des organes semblent être un sujet tout indiqué pour les premiers travaux de cet organisme. La société pourrait tirer un profit inestimable de l'existence d'un tel centre de recherches, qui lui fournirait une information compétente et objective à propos des bienfaits et des risques des nouvelles techniques et de leurs effets sur les plans biologique, économique, juridique et éthique.

L'investissement de ressources dans les techniques de remplacement des tissus impose des choix difficiles sur le plan de la micro-attribution également. Selon quels critères médicaux, éthiques et juridiques procédera-t-on à l'attribution des organes, à l'établissement des cas prioritaires pour les personnes sur les listes d'attente en vue d'une transplantation ? Et peu importe les critères retenus — besoins médicaux, date d'inscription sur la liste, hasard, âge, situation sociale — il faudra vérifier s'ils répondent aux notions fondamentales d'équité. Le fait de considérer les tissus et les organes prélevés comme une ressource nationale précieuse peut accentuer la nécessité de les répartir de façon équitable et efficace. Cette façon de voir peut en outre nous inciter à partager nos ressources, dans ce domaine, avec les nations qui en sont dépourvues. Ces questions mettent en jeu des valeurs fondamentales et des problèmes urgents touchant la justice distributive ; aussi méritent-elles une attention immédiate et soutenue de la part des pouvoirs publics, des professionnels de la santé, des universitaires et du public.

1139. Voir également *supra*, pp. 37-39.

1140. Voir A. LEAF, « Cost Effectiveness as a Criterion for Medicare Coverage » (1989), 321:13 *N. Engl. J. Med.* 898.

B. Prélèvement, transformation et commercialisation de cellules et de tissus humains

Qui est — ou qui devrait être — titulaire des droits d'usage de brevets et d'exploitation commerciale à l'égard de produits thérapeutiques mis au point à partir de cellules et de tissus humains grâce à la biotechnologie ? Le droit actuel ne fournit pas de réponses claires aux patients, aux personnes qui prêtent leur concours à des recherches, aux chercheurs ou à l'industrie de la biotechnologie. Cette incertitude est susceptible d'augmenter les possibilités de litiges. Une étude multidisciplinaire des problèmes qui se posent et des solutions possibles permettrait sans doute jusqu'à un certain point de clarifier les choses sur les plans du droit et de l'éthique.

C. Prélèvement de tissus fœtaux

Des études préliminaires permettent de croire que l'utilisation de tissus fœtaux peut s'avérer utile pour le traitement de certaines affections telle la maladie de Parkinson, caractérisée par de graves troubles neurologiques. Dans quelles circonstances, le cas échéant, devrait-il être possible sur les plans éthique et juridique d'utiliser pour des transplantations thérapeutiques des cellules fœtales obtenues par suite d'interruptions volontaires et involontaires de grossesses ? Qui devrait décider ? Quelle importance faut-il accorder au fait que, par le passé, on a déjà utilisé de telles cellules pour la mise au point de vaccins ?

D. Échanges internationaux de tissus et d'organes

Dans quelle mesure y a-t-il lieu d'établir des réseaux globaux régionaux pour les échanges internationaux de tissus ? Bien que les régimes de soins de santé américain et canadien soient distincts, les deux pays partagent régulièrement des ressources médicales, notamment des organes et des tissus humains. Alors que se développent des systèmes nationaux d'attribution et de partage d'organes et de tissus, il conviendrait de se soucier davantage du partage efficace et équitable des tissus en Amérique du Nord. S'il est parfois plus efficace sur le plan médical d'expédier des organes dans l'axe nord-sud que dans l'axe est-ouest, dans quelle mesure les préoccupations d'ordre médical devraient-elles l'emporter sur le souci d'auto-suffisance nationale ? Faudrait-il, à l'instar de certains pays européens, conclure des accords pour régir les questions touchant la protection des receveurs et l'échange de substances thérapeutiques ?

E. Patients en état de mort cérébrale

Quelle est la situation, sur le plan éthique, de la personne en état de mort cérébrale qui est branchée à un respirateur ? Les protocoles hospitaliers régissant les patients devraient-il s'appliquer jusqu'au retrait du support mécanique et jusqu'à ce que le corps de la personne décédée ressemble à un cadavre au sens traditionnel du terme ? De tels protocoles pourraient peut-être résoudre les problèmes éthiques que suscite le cas des

femmes enceintes en état de mort cérébrale que l'on maintient branchées à des appareils jusqu'à la naissance de l'enfant, ou l'utilisation de patients en état de mort cérébrale aux fins de recherche ou de formation médicale[1141]. La situation éthique de ces patients décédés doit être précisée.

1141. Voir *supra*, pp. 131-136.

Sommaire des recommandations

1. L'établissement d'un régime de prélèvement et d'offre de tissus humains qui soit à la fois sûr, adéquat, équitable et efficace devrait constituer un objectif national commun, pour l'élaboration de la législation comme de la politique à ce chapitre.

2. L'élaboration et la réforme de la législation touchant les régimes de prélèvement et de remplacement de tissus humains devraient être fondées sur les principes suivants :

***a*) l'autonomie de la personne, l'inviolabilité et l'intégrité du corps humain ;**

***b*) l'altruisme et l'encouragement aux prélèvements librement consentis ;**

***c*) la gratuité et l'universalité ;**

***d*) la préservation et la protection de la vie ;**

***e*) le respect dû aux mourants, aux morts et à leur famille.**

3. Il y aurait lieu, d'une manière générale, de maintenir les principes régissant actuellement les prélèvements de tissus et d'organes sur des personnes vivantes — consentement libre et éclairé, proportionnalité du risque couru et des avantages attendus.

4. Le *Code criminel* devrait être modifié par l'adjonction d'une clause précisant que les dispositions sur les atteintes à l'intégrité corporelle sont inapplicables à l'égard des prélèvements de tissus ou d'organes auxquels le donneur a consenti librement et en pleine connaissance de cause, pourvu que le risque ne soit pas hors de proportion avec les avantages attendus.

5. Les prélèvements effectués sur des personnes incapables de donner un consentement devraient être considérés comme légitimes pourvu qu'un tiers indépendant (tribunal, comité, ombudsman, etc.) se soit, dans chaque cas, assuré que les conditions suivantes sont remplies :

***a*) dans le cas de la moelle osseuse et des tissus non susceptibles de régénération, le donneur et le receveur doivent être apparentés ;**

***b*) on a épuisé toutes les autres possibilités de prélèvements et de traitements médicaux ;**

***c*) l'intervention ne comporte aucun risque sérieux pour le donneur ;**

d) le risque n'est pas hors de proportion avec les avantages attendus ;

e) le consentement du tuteur a été obtenu ;

f) le consentement du donneur a été obtenu lorsque la chose est possible, et son refus doit toujours être respecté.

6. Le critère de la « cessation irréversible de l'ensemble des fonctions cérébrales », proposé par la Commission il y a dix ans dans son rapport n° 15, ne devrait pas être modifié en vue de faciliter les prélèvements d'organes sur des nouveau-nés anencéphales mourants ou sur tout autre patient ne satisfaisant pas pleinement à ce critère.

7. (1) Il y aurait lieu de maintenir et de renforcer, à l'égard des prélèvements sur des personnes décédées, le régime du consentement exprès, qui est préférable du point de vue de l'intérêt public.

(2) Il y aurait lieu de respecter légalement la volonté des personnes ayant exprimé le souhait que l'on effectue des prélèvements sur leur cadavre.

8. (1) Les hôpitaux devraient établir par écrit des protocoles et des lignes de conduite, et envisager l'application de mécanismes de sensibilisation, afin de résoudre le problème des donneurs potentiels n'ayant pas exprimé leur volonté.

(2) Santé et Bien-être social Canada devrait élaborer et diriger un projet pilote dans des hôpitaux désignés relevant de la compétence fédérale, afin de mettre en application des mécanismes de sensibilisation et d'en déterminer les effets.

(3) Santé et Bien-être social Canada devrait encourager les autres hôpitaux et les provinces à participer à ce projet pilote, en mettant des crédits fédéraux à la disposition des autres hôpitaux disposés à mettre en application des mécanismes de sensibilisation et à rendre compte des résultats.

9. (1) L'article 182 du *Code criminel* devrait être remplacé par une disposition incriminant le fait de manquer de respect à l'égard d'un cadavre humain ou de restes humains.

(2) Le Rapport n° 31 de la Commission devrait être modifié par l'adjonction, aux crimes contre l'ordre public proposés (chapitre 22), de la disposition suivante :

> Manque de respect à l'égard d'un cadavre. Commet un crime quiconque, à dessein ou par témérité, manque de respect à l'égard d'un cadavre humain ou de restes humains.

10. (1) Il y aurait lieu d'établir clairement par des dispositions législatives que les dispositions de la *Loi sur les aliments et drogues* fédérale consacrées à la « protection des patients » s'appliquent à toutes les techniques de remplacement de tissus humains, de façon que celles-ci soient soumises à des normes de sécurité nationales minimales et uniformes.

(2) Par conséquent, la *Loi sur les aliments et drogues* devrait être modifiée par l'adjonction d'une nouvelle partie consacrée à la réglementation des techniques de remplacement de tissus humains, définies de façon large.

11. (1) Il y aurait lieu d'établir une infraction au *Code criminel* à l'égard de l'achat et de la vente de cadavres humains, d'organes humains ou d'autres tissus humains non susceptibles de régénération.

(2) Dans la détermination de la portée de cette disposition, le législateur devrait exclure de la définition du terme « vente » le remboursement des frais raisonnables de déplacement ou d'hébergement engagés par le donneur, les pertes de salaire raisonnables subies par lui, ainsi que les paiements raisonnables liés au prélèvement, au transport, au traitement, à la conservation et à l'utilisation thérapeutique des tissus.

12. Il y aurait lieu de considérer comme des biens visés par les dispositions du droit pénal relatives au vol les restes humains ou les substances corporelles humaines qui sont en la possession légitime d'une personne ou qu'une personne s'est légalement procurés et a transformés, par son savoir-faire et son travail, en spécimens anatomiques, tissus traités et conservés, pièces de musée, etc.

13. (1) Lorsque des professionnels de la santé, des hôpitaux ou des chercheurs acquièrent un intérêt commercial dans les tissus ou les cellules d'un patient, ou lorsque l'existence d'un tel intérêt est raisonnablement prévisible, ils devraient être tenus d'en informer le patient.

(2) Lorsqu'il devient raisonnablement clair que l'existence d'un tel intérêt commercial risque d'empêcher le professionnel de la santé d'exercer son jugement professionnel en tenant compte uniquement du bien de son patient, ce professionnel devrait être tenu de confier ce dernier à un confrère ou à une consœur.

(3) Lorsque le professionnel de la santé a informé son patient d'un tel intérêt commercial, on devrait donner au patient l'occasion de refuser la poursuite de son concours ou la continuation du traitement ; et dans le cas d'un tel refus, le professionnel de la santé devrait être tenu de confier le patient à un confrère ou à une consœur.

14. Pour l'instant, le législateur devrait s'abstenir de permettre, par des modifications à la *Loi de l'impôt sur le revenu*, des déductions ou des crédits fiscaux pour le don de tissus ou d'organes.

Glossaire médical

ACIDE DÉSOXYRIBONUCLÉIQUE (ADN) : Molécule organique contenant les informations génétiques dans presque toutes les cellules vivantes.

ADN RECOMBINANT : Également appelé clonage des gènes et génie génétique, ce processus consiste dans le transfert de certaines parties de l'ADN d'une cellule à une autre, de sorte que la cellule receveuse puisse exprimer et copier la composition génétique de la cellule donneuse. Les médicaments dérivés de tissus humains et animaux par l'ADN recombinant sont devenus des produits importants de la révolution biotechnologique.

ALBUMINE : Voir PRODUITS SANGUINS.

ANÉMIE : Déficience des globules rouges du sang, empêchant le transport de l'oxygène vers les tissus et les organes. Importante complication de l'insuffisance rénale chronique, cette affection frappe souvent les personnes ayant subi une transplantation rénale ou les patients en dialyse ; elle se caractérise par la fatigue, la léthargie et la perte d'appétit. Elle est généralement traitée par l'administration de suppléments de fer ou, dans les cas extrêmes, par des transfusions sanguines.

ANENCÉPHALIE : Anomalie de naissance, mortelle, caractérisée par l'absence d'encéphale, d'os crâniens et de cheveux.

BIOPROSTHÉTIQUE/BIOSYNTHÉTIQUE : Termes utilisés pour décrire des agents thérapeutiques dérivés partiellement de tissus naturels et partiellement de procédés synthétiques, mécaniques ou artificiels.

DIALYSE RÉNALE : Traitement au cours duquel les impuretés et les substances toxiques sont filtrées et enlevées du sang par un dialyseur, appareil communément appelé rein artificiel.

DURE-MÈRE : Membrane dure qui recouvre et protège le cerveau. Dans le domaine de la transplantation, les dures-mères traitées sont utilisées lors de la chirurgie de reconstruction du cerveau.

ÉPIKÉRATOPHALSIE : Implantation chirurgicale de tissus oculaires humains prélevés, traités et conservés, puis façonnés pour être adaptés au patient. L'implant est parfois appelé une lentille cornéenne vivante.

ÉRYTHROPOÏÉTINE (EPO) : Protéine produite dans les reins qui stimule la production de globules rouges. L'EPO tiré de l'ADN recombinant est disponible depuis peu à titre de médicament pour traiter l'anémie chronique chez les patients ayant subi une transplantation rénale et les patients en dialyse.

FACTEUR VIII : Voir PRODUITS SANGUINS.

HORMONE DE CROISSANCE HUMAINE (HCH) : Produite dans l'hypophyse, l'HCH aide à régulariser la croissance des enfants. Autrefois dérivée d'hypophyses prélevées sur des cadavres, l'HCH est désormais produite à l'aide de la technologie de l'ADN recombinant.

KÉRATOPLASTIE : Remplacement chirurgical d'une cornée (la fenêtre transparente qui couvre l'œil) défectueuse.

LENTILLE INTRAOCULAIRE : Lentille (synthétique) implantée dans l'œil pour en modifier la structure et la fonction, et utilisée en remplacement du cristallin de l'œil.

LIGNÉE CELLULAIRE : Ensemble cellulaire qui se reproduit à l'infini, dérivé de la culture in vitro de cellules vivantes.

PLASMA : Voir PRODUITS SANGUINS.

PRODUITS BIOLOGIQUES : Catégorie spéciale de médicaments dérivés de tissus humains et animaux.

PRODUITS SANGUINS : Produits thérapeutiques dérivés des globules rouges du sang et des composantes du plasma du sang entier.

- ALBUMINE : Dérivé fabriqué à partir du plasma humain et utilisé dans le traitement des brûlures, des chocs et de certaines affections.
- FACTEUR VIII : Agent de coagulation du sang fabriqué à partir du plasma humain.
- PLASMA : Partie liquide du sang, dans laquelle se trouvent en suspension les globules rouges, les globules blancs et les plaquettes. Le sang humain est constitué de plasma pour environ 55 % et d'éléments cellulaires pour environ 45 %.

ANNEXE A

Quelques déclarations d'ordre médical, éthique et juridique

(1) Association médicale Canadienne (AMC)

a) *Code de déontologie de l'AMC (Transplantations)*[1]

Pour se conformer à la déontologie médicale, le médecin doit : [. . .]

20. lorsque le cerveau est mort, entretenir la vie cellulaire du corps si certains organes doivent servir à prolonger la vie ou améliorer la santé d'autrui ;

21. s'acquitter de sa responsabilité envers la personne donneuse d'un organe en lui expliquant clairement, à elle ou à ses parents, comment il entend procéder et pourquoi ; si elle est vivante au moment du prélèvement, lui expliquer également le danger qu'elle court ;

22. s'abstenir de déterminer l'heure de la mort de la personne donneuse lorsqu'il se peut qu'il participe lui-même à la transplantation ou que ses relations avec le/la malade qui doit recevoir l'organe peuvent influer sur son jugement ;

23. il peut, une fois la transplantation faite, traiter la personne ayant reçu l'organe, même si le médecin a lui-même déterminé le moment de la mort de la personne donneuse ; [. . .]

b) *Sommaire de politique de l'AMC : le don d'organes*[2]

Les transplantations d'organes sont désormais considérées comme thérapeutiques — et non plus seulement comme expérimentales — et l'opinion publique est généralement favorable au don d'organes. Il n'y a pas, par ailleurs, de pénurie de donneurs éventuels, mais la demande en est venue à dépasser l'offre, et ce phénomène résulte jusqu'à un certain point de l'attitude du corps médical, qui ne s'est pas engagé à prendre des mesures concrètes pour trouver des donneurs éventuels et pour obtenir le consentement des membres de leur famille immédiate. Jugeant qu'elle se doit d'aider à combler cette lacune, l'AMC adhère au principe de « l'appréciation attestée », qui veut que le personnel des hôpitaux soit tenu, dans le cadre de ses activités courantes, d'apprécier à temps, et suivant des critères précis, l'éventualité d'un don d'organes de la part de ses patients qui sont mourants ou dont le cerveau est cliniquement mort, et que le médecin traitant en atteste dans le dossier médical du patient. Elle a en outre décidé de donner l'exemple, en menant une campagne de recrutement de donneurs d'organes auprès de tous les médecins du Canada et des membres de leur famille immédiate, qui seront invités à signer une carte de consentement au don d'organes.

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1. ASSOCIATION MÉDICALE CANADIENNE, *Code de déontologie*, Ottawa, l'Association, 1990.

2. (1987), 136:6 *Journal de l'Association médicale canadienne* 752B.

(2) Association des infirmières et infirmiers du Canada

Énoncé de position sur la transplantation d'organes[3]

L'Association des infirmières et infirmiers du Canada reconnaît que la transplantation d'organes et de tissus a évolué de façon à devenir un traitement de remplacement pour les insuffisances d'organes. De plus, L'AIIC reconnaît que des transplantations réussies peuvent améliorer la qualité de vie, accroître la durée de vie et réduire les coûts des soins. Par conséquent, l'AIIC appuie le concept des programmes de don, d'obtention et de transplantation d'organes et de tissus, tout en reconnaissant que le principal obstacle à l'établissement de programmes fructueux est la question de l'obtention d'organes de donneurs.

(3) Résolution de l'Association du Barreau canadien

Amendement à la (aux) loi(s) sur le don de tissus humains[4]

ATTENDU QUE les services de transplantation constituent une part importante du système canadien des services de santé (lesquels sont à présent fiables, efficaces et disponibles à l'échelle du pays) ;

ET ATTENDU QU'il arrive que le personnel hospitalier omette de demander aux représentants des personnes décédées si elles consentent à un don de tissus, même en sachant que des personnes ne survivront pas en l'absence d'une transplantation d'organe ;

ATTENDU QUE des sondages révèlent que les Canadiens sont en grande majorité extrêmement favorables aux programmes de transplantation, mais que seul un petit groupe de Canadiens donnent des instructions en vue de faire don de leurs tissus ;

ATTENDU QUE 85 à 90 pour cent des familles et/ou des représentants d'un parent décédé, desquels le consentement à un don de tissus est sollicité, acceptent qu'un tel don soit effectué et que les familles et/ou les représentants de personnes décédées ont souvent exprimé leur regret de ne pas avoir eu l'occasion de consentir à un don de tissus ;

ATTENDU QUE les familles et/ou les représentants des personnes décédées, à qui l'occasion de faire un don de tissus a été offerte et qui y ont consenti, déclarent que ce don les a aidés à surmonter leur douleur, quelque temps après le décès et même au cours des mois et des années qui ont suivi ce décès ;

QU'IL SOIT RÉSOLU QUE l'Association du Barreau canadien presse les gouvernements fédéral, provinciaux et territoriaux à amender ou à promulguer une loi, laquelle imposerait des obligations de nature réglementaire au personnel hospitalier pour demander une autorisation ou pour faire en sorte qu'une autorisation soit requise auprès du représentant de la personne décédée en vue d'utiliser l'un ou tous les tissus de la personne décédée.

(4) Association médicale mondiale

Déclaration sur les transplantations d'organes humains
39e Assemblée médicale mondiale : Madrid, octobre 1987[5]

« L'Association médicale mondiale recommande les directives suivantes aux médecins concernés par les transplantations d'organes humains :

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3. « Énoncé de position sur le rôle des infirmières dans le don, l'obtention et la transplantation d'organes et de tissus » (1987), *Énoncé de position de l'Association des infirmières et infirmiers du Canada*.

4. Résolution no 4, adoptée (1989), 16:3 *National* 22.

5. « L'Association médicale mondiale adopte des déclarations sur des questions d'ordre bioéthique et autres » (1988), 39:1 *R.I.L.S.* 286.

1. La première préoccupation du médecin doit, en toutes circonstances, être la santé de ses patients. Cette préoccupation, ainsi que la fidélité, doivent être préservées dans toutes les interventions médicales, y compris celles qui impliquent la transplantation d'un organe d'une personne à une autre. Le donneur et le receveur sont des patients. C'est pourquoi il faut veiller à protéger les droits de l'un et de l'autre. Aucun médecin ne peut donc assumer la responsabilité d'une transplantation si ces droits ne sont pas protégés.

2. Un projet de transplantation d'organe ne justifie aucunement le relâchement des exigences en matière d'éthique médicale. Les mêmes exigences doivent être respectées, que le patient soit un donneur potentiel ou non.

3. Lorsqu'en vue d'une transplantation un organe doit être prélevé sur un donneur après le décès de celui-ci, ce décès doit avoir été certifié en toute indépendance par deux ou plusieurs médecins qui ne sont pas concernés par la transplantation. Le décès doit être déterminé par le jugement de chaque médecin. En procédant à cette détermination, chaque médecin aura recours aux méthodes scientifiques reconnues et se basera sur des critères répondant aux exigences éthiques et aux normes professionnelles définies par l'association médicale nationale et les autres organisations médicales compétentes.

4. Lorsqu'une procédure expérimentale est envisagée (transplantation d'organe animal ou artificiel), le médecin devra se conformer aux recommandations émises dans la Déclaration d'Helsinki de l'Association médicale mondiale et qui visent à guider les médecins en matière de recherches biomédicales impliquant des sujets humains.
[...]

(5) Organisation mondiale de la santé (OMS)

a) Principes directeurs sur la transplantation d'organes humains[6]

PRÉAMBULE

1. [...] Au cours des 30 dernières années, la transplantation d'organes s'est répandue dans le monde entier et a permis de sauver plusieurs milliers de vies. Elle a également permis d'améliorer la qualité de la vie dans d'innombrables autres cas. Les progrès constants de la technologie médicale, notamment dans le domaine du « rejet » des tissus, ont favorisé une extension de la pratique et provoqué une augmentation de la demande d'organes. Une des caractéristiques de la transplantation d'organes depuis le début est le manque d'organes à transplanter. L'offre n'a jamais permis de faire face à la demande, ce qui a conduit dans de nombreux pays à l'élaboration constante de procédures et de systèmes destinés à accroître l'offre d'organes. On peut soutenir de façon rationnelle que cette pénurie a entraîné une augmentation du trafic commercial d'organes humains, notamment d'organes provenant de donneurs vivants non apparentés aux receveurs. Il existe des éléments de preuve de l'existence d'un tel trafic au cours des dernières années et des craintes ont également été manifestées quant à la possibilité d'un trafic portant sur des êtres humains. Les résolutions WHA40.13 et WHA42.5 de l'Assemblée de la Santé sont une expression des préoccupations internationales devant l'évolution de la situation.

2. Ces Principes directeurs visent à fournir un cadre ordonné, éthique et acceptable pour réglementer l'acquisition et la transplantation d'organes humains à des fins thérapeutiques. L'expression « organe humain » s'entend des organes et des tissus mais ne se réfère pas à la reproduction

6. Adoptés par la résolution WHA44.25 de la 44e Assemblée générale de l'OMS le 13 mai 1991, reproduit dans (1991), 42:3 *R.I.L.S.* 422. La Commission n'a pas étudié la version officielle de ces principes, celle-ci ayant été adoptée postérieurement à l'approbation de ses recommandations.

humaine, et par conséquent ne s'étend ni aux tissus ou éléments liés à la reproduction, à savoir les ovules, le sperme, les ovaires, les testicules ou les embryons, ni au sang ou constituants sanguins utilisés aux fins de la transfusion. Les Principes directeurs excluent la possibilité de donner ou de recevoir une contrepartie pécuniaire, de même que toute autre transaction commerciale dans ce domaine, mais sans s'opposer au règlement des dépenses encourues lors du prélèvement, de la conservation et de la fourniture d'un organe. L'OMS entend tout particulièrement protéger les mineurs et les autres personnes vulnérables contre toute contrainte ou toute incitation abusive au don d'organes.

Les organes et tissus (ci-après les « organes ») peuvent être prélevés sur le corps de personnes décédées et sur des personnes vivantes aux fins de transplantation seulement en conformité avec les Principes directeurs suivants.

PRINCIPE DIRECTEUR 1

Des organes peuvent être prélevés sur le corps de personnes décédées aux fins de transplantation :

a) si tous les consentements prévus par la loi ont été obtenus ; et

b) s'il n'y a pas de raison de croire que la personne décédée s'opposait audit prélèvement, en l'absence d'un consentement formel donné de son vivant.

PRINCIPE DIRECTEUR 2

Les médecins constatant le décès d'un donneur potentiel ne doivent pas participer directement au prélèvement d'organes du donneur et aux étapes ultérieures de la transplantation, ni être chargés de soigner des receveurs potentiels de ces organes.

PRINCIPE DIRECTEUR 3

Les organes à transplanter doivent être prélevés de préférence sur le corps de personnes décédées. Les adultes vivants peuvent toutefois faire don d'organes mais, en général, il doit exister un lien génétique entre le donneur et le receveur. Des exceptions sont possibles en cas d'une greffe de moelle osseuse et d'autres tissus régénérables qui soient acceptables.

Un organe peut être prélevé sur un donneur vivant adulte aux fins de transplantation si celui-ci y consent librement. Le donneur ne doit être soumis à aucune influence ou pression abusive et doit être suffisamment bien informé pour pouvoir comprendre et évaluer les risques, les avantages et les conséquences de son consentement.

PRINCIPE DIRECTEUR 4

Aucun organe ne doit être prélevé sur un mineur vivant aux fins de transplantation. Des exceptions peuvent être prévues par la législation nationale s'il s'agit de tissus régénérables.

PRINCIPE DIRECTEUR 5

Le corps humain et les parties de corps humain ne peuvent faire l'objet de transactions commerciales. En conséquence, il est interdit de donner ou de recevoir une contrepartie pécuniaire (ou toute autre compensation ou récompense) pour des organes.

PRINCIPE DIRECTEUR 6

Il est interdit de faire de la publicité sur le besoin d'organes ou sur leur disponibilité en vue d'offrir ou de rechercher une rémunération.

PRINCIPE DIRECTEUR 7

Les médecins et les autres professionnels de la santé ne doivent participer à aucune des phases de transplantations d'organes s'ils ont des raisons de croire que les organes destinés à ces transplantations ont fait l'objet de transactions commerciales.

PRINCIPE DIRECTEUR 8

Aucune personne ou aucun service participant à une transplantation d'organes ne doit recevoir de rémunération dépassant le montant justifié par les services rendus.

PRINCIPE DIRECTEUR 9

A la lumière des principes de justice distributive et d'équité, les organes donnés doivent être mis à la disposition des malades sur la base des exigences médicales et non sur la base de considérations financières ou autres.

COMMENTAIRES . . .

b) Résolution de l'OMS pour l'interdiction de l'achat et de la vente d'organes humains[7]

La Quarante-Deuxième Assemblée mondiale de la Santé,

Préoccupée par le trafic commercial d'organes de donneurs sains, qui exploite la détresse humaine et constitue un risque accru pour la santé des donneurs ;

Consciente des transactions commerciales dont les transplantations d'organes font néanmoins l'objet et du peu de succès des efforts déployés jusqu'ici pour empêcher le trafic d'organes humains ;

Désireuse d'empêcher l'exploitation de la détresse humaine, en particulier chez les enfants et d'autres groupes vulnérables, et de promouvoir la reconnaissance des principes éthiques qui condamnent l'achat et la vente d'organes aux fins de transplantation ;

1. DEMANDE aux États membres de prendre des mesures appropriées pour empêcher l'achat et la vente d'organes humains en vue de leur transplantation ;

2. RECOMMANDE aux États Membres d'adopter des mesures législatives pour interdire le trafic d'organes lorsqu'il ne peut être efficacement empêché par d'autres mesures ;

3. PRIE INSTAMMENT les États Membres, en coopération étroite avec les organisations des professions de santé et les autorités sanitaires de tutelle, de décourager toutes pratiques qui facilitent le trafic commercial des organes ;

4. PRIE les États Membres de faire rapport le plus tôt possible à l'OMS sur l'action entreprise pour donner suite à la présente résolution ;

5. PRIE le Directeur général de faire rapport à la Quarante-Quatrième Assemblée mondiale de la Santé sur les mesures prises par les gouvernements des États Membres en application de la présente résolution.

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7. « Adoption par l'Assemblée mondiale de la Santé d'une résolution pour l'interdiction de l'achat et de la vente d'organes humains » (1989), 40:3 *R.I.L.S.* 783.

ANNEXE B

Législation : extraits

(1) Demande obligatoire, mécanismes de sensibilisation

a) *Manitoba* (*Loi sur les tissus humains*, L.M. 1987-88, ch. 39)

Points à prendre en considération

4(1) Au décès d'une personne à l'égard de laquelle aucune directive n'a été donnée en application des articles 2 ou 3, [. . .] le dernier médecin qui a eu soin de la personne avant son décès doit, [. . .] étudier les questions énumérées ci-dessous afin de déterminer s'il est opportun de demander la permission, conformément au paragraphe (2), d'utiliser le corps du défunt ou d'en prélever des tissus à des fins thérapeutiques :

a) l'état du corps et des tissus du corps du défunt ;

b) le besoin d'utiliser le corps du défunt ou ses tissus à des fins thérapeutiques ;

c) l'état physique et émotionnel des survivants du défunt.

Demande

4(2) Le médecin demande au plus proche parent du défunt la permission, ou fait demander la permission, d'utiliser le corps ou d'en prélever des tissus à des fins thérapeutiques le plus tôt possible après le décès [. . .] s'il juge opportun de le faire après étude de la situation conformément au paragraphe (1).

Exception

4(3) Le présent article ne s'applique pas lorsque le dernier médecin qui a eu soin d'une personne avant son décès a des motifs de croire :

a) que l'utilisation du corps du défunt ou le prélèvement et l'utilisation de tissus de son corps seraient contraires aux croyances religieuses du défunt ou que celui-ci, s'il avait été vivant, y aurait fait objection ;

b) qu'une enquête ou une investigation peut être requise en application de la Loi sur les enquêtes médico-légales [. . .]

b) *Oregon* (chapitre 379, Lois de 1985, House Bill No. 2909, approuvée le 3 juillet 1985)

[TRADUCTION]

ARTICLE 1. (1) Lorsqu'une personne décède dans un hôpital et qu'elle n'a pas fait de don anatomique, l'administrateur ou la personne désignée par celui-ci demande à la personne décrite dans ORS 97.265(2), selon l'ordre de priorité établi, lorsqu'il est impossible au moment du décès de retracer les personnes figurant dans les catégories préalables, et en l'absence d'avis d'une indication contraire par le défunt ou l'une des personnes figurant dans les catégories préalables, de consentir au prélèvement de toutes les parties du corps du défunt, ou de certaines d'entre elles.

(2) La demande et la réponse doivent être consignées dans le dossier médical du patient et sur le certificat de décès, selon la manière prescrite dans ORS 97.275(5).

(3) Lorsque, en raison de critères médicaux, les parties du corps ne pourraient pas être utilisées, le directeur adjoint des services de santé peut autoriser une exception concernant la demande exigée par le présent article.

(4) Le directeur adjoint des services de santé énonce des règles concernant la formation des employés de l'hôpital pouvant être désignés pour présenter la demande et la procédure à suivre le cas échéant. En outre, il établit les règles nécessaires en vue de la mise en œuvre des procédures visant à faciliter le transport des organes prélevés aux hôpitaux où se trouvent des receveurs potentiels.

(5) Le directeur adjoint des services de santé établit toutes les autres règles nécessaires à la mise en œuvre du présent article.

c) *États-Unis* (*National Organ Transplant Act* de 1984, 42 USC, § 1320b-8)

[TRADUCTION]
§ 1320b-8. Protocoles hospitaliers concernant le prélèvement d'organes et normes applicables aux organismes de prélèvement d'organes.

a) Établissement de protocoles

(1) Le Secrétaire doit faire en sorte qu'un [. . .] hôpital satisfaisant aux exigences stipulées au titre VIII ou XIX [42USC – 1395 et suiv., 1396 et suiv.] ne puisse participer au programme établi en vertu de ce titre que si :

(A) l'hôpital [. . .] adopte, pour la désignation des donneurs potentiels, des protocoles écrits qui

(i) prévoient que les familles des donneurs d'organes potentiels doivent être informées de la possibilité de consentir au prélèvement de tissus ou d'organes et de leur droit de refuser de le faire,

(ii) encouragent la discrétion et la prise en considération des circonstances ainsi que des idées et des croyances des familles,

(iii) prévoient qu'un organisme de prélèvement d'organes désigné par le Secrétaire conformément à l'alinéa *b*)(1)(F) doit être avisé de la désignation de donneurs potentiels ;

[. . .]

(2) pour l'application du présent paragraphe, le mot « organe » s'entend des reins, du foie, du cœur, des poumons, du pancréas et de tout autre organe ou tissu humain désigné par le Secrétaire à cette fin.

d) *Australie* (COMMISSION DE RÉFORME DU DROIT DE L'AUSTRALIE, *Human Tissue Transplants*, Rapport n° 7, Brisbane, Watson Ferguson and Co., 1977), pp. 127-128.

[TRADUCTION]
25. (3) L'agent désigné peut autoriser le prélèvement des tissus d'une personne décédée, aux fins prévues au paragraphe (1) lorsque, après avoir procédé aux vérifications raisonnables dans les circonstances, il n'a aucun motif de croire que le défunt, de son vivant,

a) soit a exprimé le souhait que l'on effectue sur son corps, après son décès, des prélèvements aux fins visées au paragraphe (1),

b) soit a manifesté une objection à cet égard ;

et lorsque, après avoir procédé aux autres vérifications raisonnables dans les circonstances,

c) soit il n'a aucun motif de croire que le plus âgé des proches parents ayant pu être retracés s'oppose à des prélèvements sur le défunt,

d) soit il lui est impossible de savoir s'il y a des proches parents, de retrouver ceux-ci, ou de vérifier si l'un des proches parents s'oppose à des prélèvements sur le défunt.

(2) Interdiction de la vente de tissus humains

a) *Canada*

i. *Loi uniforme sur les dons de tissus humains*, Conférence sur l'uniformisation des lois au Canada (révision de 1971) (en vigueur dans la plupart des provinces)[1]

Interdiction de vendre un tissu, etc.

10. Nul ne doit, directement ou indirectement, acheter, vendre ou autrement trafiquer, contre valeur, un tissu destiné à une transplantation, ou un corps ou l'une de ses parties, à l'exception du sang et ses composants, à des fins thérapeutiques, pour l'enseignement de la médecine ou pour la recherche scientifique. Une transaction de ce genre est nulle en raison du fait qu'elle est contraire à l'ordre public.

1. Les définitions qui suivent [. . .]

d) « tissu » S'entend d'un organe, mais non de la peau, des os, du sang ou de ses composants, ou de tout autre tissu se renouvelant par un processus naturel de régénération.

ii. *Loi uniforme sur le don de tissus humains* (1989), Conférence sur l'uniformisation des lois au Canada

Interdiction relative au commerce

15. (1) Nul ne peut acheter ou vendre, directement ou indirectement, un tissu, un corps ou une partie de corps humain, ou en faire le commerce à des fins de transplantation, d'enseignement médical, de recherche scientifique ou à des fins thérapeutiques.

(2) Tout commerce de corps ou de partie de corps humain autorisé par la loi avant que la présente loi n'entre en vigueur continuera de l'être, sauf disposition contraire contenue dans la présente loi.

(3) La personne qui contrevient aux dispositions du présent article commet une infraction et se rend passible, sur déclaration sommaire de culpabilité, d'une amende d'au plus 100 000 $ ou d'un emprisonnement d'au plus un an, ou de ces deux peines concurremment.

1. Les définitions qui suivent [. . .]

« tissu » signifie toute partie du corps humain, vivant ou mort, à l'exception :

a) des spermatozoïdes et des ovules,

b) des embryons et des fœtus, ou

c) du sang et de ses dérivés ; (« tissue »)

iii. Manitoba (*Loi sur les tissus humains*, L.M. 1987-88, ch. 39)

Interdiction relative au commerce

15 (2) Nul ne peut, pour quelque fin que ce soit :

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1. Texte publié dans : SBSC, CENTRE FÉDÉRAL SUR LE SIDA, « Lignes de conduite pour la prévention de l'infection à VIH dans la transplantation d'organe et de tissu » (octobre 1989), 15S4 (Suppl.) *Rapport hebdomadaire des maladies au Canada* 13.

a) aliéner ou acquérir un cadavre ou tout tissu provenant du corps d'une personne vivante ou décédée ;

b) faire le commerce des cadavres ou des tissus provenant du corps d'une personne vivante ou décédée, [...]

Exception relative à la rémunération

15 (3) Le présent article n'a pas pour effet d'interdire le paiement d'une rémunération raisonnable à un médecin ou à tout autre professionnel de la santé en échange des services qu'il rend pour que soient respectées les directives ou qu'il soit tenu compte d'un consentement donné en application de la présente loi.

Exception relative aux dépenses

15 (4) Le présent article n'a pas pour effet d'interdire le remboursement au donneur ou au bénéficiaire d'un corps ou de tissus en provenant, à la famille ou aux survivants d'une telle personne, à un gouvernement, ou à un régime d'assurance-maladie ou d'assurance-hospitalisation, selon le cas, des dépenses raisonnables faites [...]

Infraction et peine

15 (5) La personne qui contrevient aux dispositions du présent article ou qui fait défaut de les observer commet une infraction et se rend passible, sur déclaration sommaire de culpabilité, d'une amende d'au plus 5 000 $ ou d'un emprisonnement d'au plus six mois, ou de ces deux peines concurremment.

b) *Grande-Bretagne* (Loi de 1989 relative aux transplantations d'organes humains, ch. 31[2]).

1.1. En Grande-Bretagne, une personne est coupable d'un délit si elle :

a) effectue ou reçoit un quelconque paiement pour la délivrance ou l'offre de délivrance d'un organe qui a été ou doit être prélevé sur le corps d'une personne décédée ou vivante et qui est destiné à être transplanté sur une autre personne, que ce soit en Grande-Bretagne ou ailleurs ;

b) essaie de trouver une personne qui consente à fournir contre paiement un organe mentionné à l'alinéa *a*) ci-dessus ou offre de fournir un tel organe contre paiement ;

c) est l'instigateur ou le négociateur d'un arrangement impliquant le versement d'un quelconque paiement en échange de la délivrance ou de l'offre de délivrance d'un tel organe ;

d) participe à la gestion ou au contrôle d'une entreprise constituée en société ayant personnalité morale ou civile dont les activités impliquent ou incluent l'instigation ou la négociation de tels arrangements.

2. [...] si elle fait publier ou distribuer ou publie ou distribue intentionnellement en Grande-Bretagne une annonce publicitaire :

a) invitant des personnes à fournir contre paiement un quelconque organe visé à l'alinéa *a*) dudit paragraphe ou offrant de fournir un tel organe contre paiement ;

b) précisant que l'annonceur consent à être l'instigateur ou le négociateur d'un quelconque arrangement visé à l'alinéa *c*) dudit paragraphe.

3. Dans le présent article, « paiement » s'entend [...] à l'exclusion [...]

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2. Publiée dans : (1989), 40:4 *R.I.L.S.* 911.

a) des frais de prélèvement, de transport ou de conservation de l'organe devant être fourni ;

b) des frais ou du manque à gagner encourus par une personne, dans la mesure où ils sont raisonnablement et directement imputables à la fourniture d'un organe en provenance de son corps.

c) *États-Unis* (*National Organ Transplant Act* de 1984, 42 USC, § 274*e*))

[TRADUCTION]
§ 274e. Interdiction de l'achat d'organes [c'est nous qui soulignons]

a) Interdiction

Il est interdit à quiconque d'acheter, de recevoir ou d'autrement transférer, *volontairement*, tout organe humain contre valeur aux fins de transplantation sur une autre personne, si la cession touche le commerce entre États.

b) Peines

Quiconque contrevient à l'alinéa *a*) [. . .] est passible d'une amende n'excédant pas 50 000 $ ou d'un emprisonnement d'au plus cinq ans, ou des deux peines concurremment.

c) Définitions

Pour l'application de l'alinéa *a*) [. . .]

(1) Le terme « organe humain » s'entend des reins, du foie, du cœur, des poumons, du pancréas, de la moelle osseuse, de la cornée, des yeux, des os et de la peau, ou de toute partie de ceux-ci, y compris les organes prélevés sur les fœtus, et de tous autres organes ou parties de ceux-ci, y compris ceux prélevés sur les fœtus, désignés par règlement pris par le Secrétaire de la santé et des services sociaux.

(2) Le terme « contre valeur » ne vise pas les frais raisonnables liés au prélèvement, au transport, à l'implantation, au traitement, à la conservation, au contrôle de la qualité et au stockage des organes humains, ni le remboursement des frais de déplacement ou d'hébergement engagés et du manque à gagner subi par le donneur.

d) *Conseil de l'Europe* (Texte final sur les transplantation d'organes (1988), 39:1 *R.I.L.S.* 294, 297)

Non-Commercialisation des organes humains

16. Aucun organe humain ne doit être cédé dans un but lucratif par un organisme d'échanges, une banque d'organes ou tout autre établissement ou particulier. Néanmoins, ce principe n'empêche pas un donneur vivant d'être remboursé des gains en revenus perdus et des frais causés par le prélèvement ou les examens préalables.

17. Aucun organisme ou particulier ne devrait faire de publicité en dehors de son territoire national, ni en vue d'une donation ni d'une transplantation.

(3) *Loi uniforme sur le don de tissus humains* (1989)[3]

Définitions

1. Les définitions qui suivent s'appliquent à la présente loi :

« *conjoint* »
« conjoint » comprend un conjoint de fait ; (« spouse ») ;

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3. CONFÉRENCE SUR L'UNIFORMISATION DES LOIS AU CANADA, *Consolidation of Uniform Acts* (Suppl. 1991), p. 22-1. Disponible pour adoption par les provinces à compter du 1er janvier 1990.

« *conjoint de fait* »
« conjoint de fait » signifie [insérer ici la définition prévue à la loi de la province intéressée] ; (« common law spouse »)

« *mort* »
« mort » comprend la mort cérébrale telle que déterminée conformément aux pratiques médicales actuelles ; (« death »)

« *tissu* »
« tissu » signifie toute partie du corps humain, vivant ou mort, à l'exception :
a) des spermatozoïdes et des ovules,
b) des embryons et des fœtus, ou
c) du sang et de ses dérivés ; (« tissue »)

« *tissu non susceptible de régénération* »
« tissu non susceptible de régénération » signifie un tissu autre que les tissus susceptibles de régénération ; (« non-regenerative tissue »)

« *tissu susceptible de régénération* »
« tissu susceptible de régénération », chez une personne vivante, signifie un tissu qui, à la suite d'une blessure ou d'un prélèvement, peut se reconstituer ; (« regenerative tissue »)

« *transplantation* »
« transplantation » signifie l'opération qui consiste à prélever un tissu sur le corps d'une personne et à l'implanter dans le corps d'une autre personne vivante ; (« transplant »)

Respect de la loi

2. Le consentement au prélèvement d'un tissu, le cas échéant, doit être donné conformément à la présente loi.

Consentement à une transplantation après la mort

3. (1) Une personne âgée de [16] ans et plus et capable de comprendre la nature et les effets de la transplantation peut consentir à ce qu'un tissu déterminé soit prélevé sur son corps après sa mort pour être implanté dans le corps d'une autre personne vivante.

(2) Toutefois, le consentement accordé par une personne qui ne comprend pas la nature et les effets de la transplantation est valide aux fins du présent article si la personne qui y a donné suite l'ignorait.

Consentement substitué

4. (1) Après la mort d'une personne qui n'a pas donné son consentement tel que prévu à l'article 3, qui était âgé de moins de [16] ans ou qui ne comprenait pas la nature et les effets du prélèvement de tissu sur son corps, une des personnes énumérées au paragraphe 2 peut consentir à ce qu'un tissu déterminé soit prélevé sur le corps du défunt

a) pour être implanté dans le corps d'une autre personne vivante, ou

b) pour les fins précisées à l'article 12(1).

(2) L'une ou l'autre des personnes suivantes peut donner le consentement visé au paragraphe 1 :

a) le curateur, le tuteur ou le mandataire du défunt ;
b) le conjoint du défunt ;
c) un enfant du défunt ;
d) le père ou la mère du défunt ;
e) un frère ou une sœur du défunt ;
f) tout autre parent du défunt ;
g) toute personne, autre que le conjoint, qui vivait avec le défunt au moment de sa mort et qui avait connaissance de ses volontés.

(3) En cas de désaccord entre des personnes appartenant à au moins deux catégories visées au paragraphe 2, le conflit sera tranché en fonction de l'ordre selon lequel ces catégories de personnes sont énumérées.

(4) Si aucun consentement n'a été accordé aux termes du paragraphe 1 et que le [coroner], après avoir déployé des efforts raisonnables, n'a réussi à localiser aucune des personnes énumérées au paragraphe 2, celui-ci peut donner lui-même le consentement.

(5) Aucun consentement ne peut être accordé aux termes du présent article par une personne qui
a) est âgée de [16] ans,
b) ne comprend pas la nature et les effets du prélèvement de tissu, ou
c) a des raisons de croire que le défunt s'y serait opposé.

Consentement à une transplantation entre vifs

5. (1) Une personne âgée de [16] ans et plus et capable de comprendre la nature et les effets de la transplantation peut consentir à ce qu'un tissu déterminé soit prélevé sur son corps de son vivant pour être implanté dans le corps d'une autre personne vivante.

(2) S'il y a des raisons de croire qu'une personne qui donne un consentement en vertu du présent article ne comprend pas la nature et les conséquences d'un prélèvement de tissu sur son corps de son vivant, aucune transplantation ne peut être effectuée aux termes du présent article, à moins que les résultats d'une étude indépendante menée conformément à l'article 7 n'indiquent qu'il y a lieu d'y procéder.

(3) Aucune transplantation de tissu non susceptible de régénération ne peut être effectuée aux termes du présent article sauf si les résultats d'une étude indépendante menée conformément à l'article 7 indiquent qu'il y a lieu d'y procéder.

Transplantation entre vifs — Personne de moins de [16] ans

6. (1) Une personne âgée de [16] ans et capable de comprendre la nature et les effets de la transplantation peut consentir à ce qu'un tissu susceptible de régénération déterminé soit prélevé sur son corps de son vivant pour être implanté dans le corps d'une autre personne vivante.

(2) Toutefois, de la moelle peut être prélevée sur une personne âgée de [16] ans qui n'est pas en mesure de comprendre la nature et les effets de la transplantation aux fins de l'implanter dans le corps de la mère, du père, du frère, de la sœur, du demi-frère ou de la demi-sœur naturels du donneur.

(3) Nulle transplantation ne peut être effectuée,

a) aux termes du paragraphe 1, sauf si le père, la mère ou le tuteur du donneur consent également à la transplantation, ou

b) aux termes du paragraphe 2, sauf si le père, la mère ou le tuteur du donneur consent à la transplantation en son nom.

(4) Nulle transplantation ne peut être effectuée aux termes du paragraphe 1 ou 2, sauf si les résultats d'une étude indépendante menée conformément à l'article 7 indiquent qu'il y a lieu d'y procéder.

Étude indépendante

7. (1) Si une étude indépendante est requise en vertu de la présente loi, elle doit être effectuée conformément au présent article et aux règlements.

(2) Une étude indépendante doit être effectuée par au moins trois personnes, dont un médecin.

(3) Aucune personne, qui a ou a eu un lien avec le donneur ou avec le récipiendaire proposé, ne peut participer à l'étude indépendante.

(4) Les membres du comité doivent indiquer la date, l'heure et le lieu où le comité se réunira pour procéder à l'étude indépendante

a) au donneur de tissu,

b) si le donneur est âgé de [16] ans, au père, à la mère ou au tuteur du donneur et au [Curateur public], et

c) si le donneur est âgé de [16] ans ou plus et qu'il y a des raisons de croire qu'il ne comprend pas la nature et les conséquences d'un prélèvement de tissus sur son corps de son vivant, à son père, à sa mère, à son tuteur et au [Curateur public].

(5) Lorsqu'il reçoit un avis en vertu du paragraphe (4), le [Curateur public] doit représenter le donneur devant le comité à moins qu'une personne autre que le père, la mère ou le tuteur n'assure déjà cette représentation.

(6) Les membres du comité doivent tenir compte des éléments suivants :

a) la transplantation est le traitement médical opportun ;

b) tous les autres membres de la famille immédiate du donneur ont été éliminés comme donneurs potentiels, que ce soit pour des raisons médicales ou autres ;

c) aucune pression n'a été exercée auprès du donneur dans le but d'obtenir qu'il consente à la transplantation ;

d) le prélèvement du tissu en question ne présente aucun risque important pour la santé du donneur ;

e) on s'est conformé à la présente loi et aux règlements relatifs à la transplantation.

(7) Les membres du comité doivent, de la manière et dans le délai prévus aux règlements :

a) décider s'il y a lieu ou non de procéder à la transplantation qu'on se propose de faire conformément à l'article 5 ou à l'article 6,

b) justifier leur décision par écrit, et

c) aviser de la décision et des motifs les personnes mentionnées au paragraphe (4).

Appel

8. (1) Une personne peut en appeler de la décision rendue par le comité chargé de l'étude indépendante auprès de la [cour Supérieure] dans les trois jours de cette décision.

(2) Après avoir été saisi de l'appel, la [cour Supérieure] peut :

a) annuler, modifier ou confirmer la décision du comité chargé de l'étude indépendante, ou

b) renvoyer la question devant le comité pour étude plus approfondie conformément à toute directive qu'elle lui donne.

(3) Après avoir été saisi d'un appel relativement à une transplantation visée par l'article 6(2), la [cour Supérieure] peut rendre une décision autorisant le père, la mère ou le tuteur du donneur à consentir à la transplantation au nom du donneur.

(4) Aucune transplantation faisant l'objet d'un appel aux termes du paragraphe 1 ne peut être effectuée tant que la procédure d'appel n'est pas terminée.

Effet du consentement

9. (1) Un consentement accordé conformément à la présente loi lie les parties et autorise un médecin à

a) procéder à un examen pour déterminer si le tissu désigné dans le consentement est médicalement acceptable, et

b) à prélever ce tissu conformément au consentement.

(2) Toutefois, nul ne donnera suite à un consentement s'il a des raisons de croire que

a) dans le cas d'un consentement visé par l'article 3, 5, 6 ou 12, la personne a ultérieurement retiré son consentement ou s'y serait opposée, ou

b) dans le cas d'un consentement visé par l'article 4, la personne au nom de qui le consentement a été accordé s'y serait opposée.

Directives du coroner

10. Si, de l'avis d'un médecin, la mort d'une personne est imminente en raison d'une blessure ou d'une maladie, qu'il a des raison de croire que l'article ... de la [loi des coroners] peut s'appliquer lorsque la mort surviendra et qu'un consentement à la transplantation d'un tissu a été accordé en application de l'article 3, le [*coroner*] habilité, en dépit du fait que la mort n'est pas encore survenue, peut donner toute directive qu'il juge appropriée relativement au prélèvement du tissu sur le cadavre de la personne, et cette directive a le même effet que si elle avait été donnée après la mort en application de l'article ... de la [*loi des coroners*].

Détermination du décès

11. (1) La détermination du moment de la mort du donneur d'un tissu doit être faite par au moins deux médecins conformément aux pratiques médicales reconnues.

(2) Le médecin qui a eu un lien quelconque avec le bénéficiaire éventuel d'un tissu transplanté ne peut participer à la détermination du moment de la mort du donneur de ce tissu.

(3) Le médecin qui a participé à la détermination du moment de la mort du donneur d'un tissu ne peut participer à la transplantation de ce tissu.

(4) Les paragraphes 2 et 3 ne s'appliquent pas au médecin qui effectue un prélèvement des yeux pour fins de transplantation de la cornée.

Consentement au don de tissu pour d'autres fins

12. (1) Malgré toute disposition contraire de la présente loi, une personne âgée de [16] ans et plus peut consentir à ce qu'on utilise son cadavre ou les parties de celui-ci désignées dans son consentement à des fins thérapeutiques ou à des fins d'enseignement médical ou de recherche scientifique.

(2) Si un tissu prélevé par suite d'un consentement accordé aux termes de l'article 3, 4, 5 ou 6 ne peut pour une raison quelconque être implanté dans le corps d'une personne vivante, le tissu sera traité comme si aucun consentement n'avait été accordé, à moins que le donneur n'ait consenti à ce qu'on utilise le tissu à des fins thérapeutiques ou à des fins d'enseignement médical ou de recherche scientifique.

Divulgation de l'information

13. (1) Sauf lorsque la loi le requiert, nul ne doit divulguer ou communiquer à une autre personne une information ou un document permettant de rendre publique l'identité d'une personne

a) qui a accordé ou refusé d'accorder son consentement à une transplantation de tissu,

b) à l'égard de qui un consentement a été accordé ou refusé, ou

c) dans le corps de qui un tissu a été, est ou pourra être implanté.

(2) Toutefois,

a) un donneur de tissus peut divulguer ou autoriser une personne à divulguer certains renseignements qui ne concernent que lui-même ;

b) un récipiendaire de tissus peut divulguer ou autoriser une personne à divulguer certains renseignements déterminés qui ne concernent que lui-même, et

c) une personne qui a donné un consentement en vertu de l'article 4 au nom d'une personne décédée peut divulguer ou autoriser une autre personne à divulguer certaines informations relatives uniquement au donneur.

Immunité

14. Nul n'est passible de poursuites en raison d'un acte qu'il a accompli ou omis d'accomplir de bonne foi et sans négligence de sa part dans l'exercice des pouvoirs conférés par la présente loi.

Interdiction relative au commerce

15. (1) Nul ne peut acheter ou vendre, directement ou indirectement, un tissu, un corps ou une partie de corps humain, ou en faire le commerce à des fins de transplantation, d'enseignement médical, de recherche scientifique ou à des fins thérapeutiques.

(2) Tout commerce de corps ou de partie de corps humain autorisé par la loi avant que la présente loi n'entre en vigueur continuera de l'être, sauf disposition contraire contenue dans la présente loi.

(3) La personne qui contrevient aux dispositions du présent article commet une infraction et se rend passible, sur déclaration sommaire de culpabilité, d'une amende d'au plus 100 000 $ ou d'un emprisonnement d'au plus un an, ou de ces deux peines concurremment.

Infraction ordinaire

[16. La personne qui contrevient aux dispositions de la présente loi, sauf l'article 15, commet une infraction et se rend passible, sur déclaration sommaire de culpabilité, d'une amende d'au plus 10 000 $ ou d'un emprisonnement d'au plus six mois, ou de ces deux peines concurremment.]

Règlements

17. Le gouvernement peut, par règlement :

a) déterminer les règles relatives aux études indépendantes ;

b) déterminer les délais et la forme des décisions rendues en vertu de l'article 7(7), de même que les règles relatives aux motifs et aux avis à donner.

Abrogation

18. La Loi uniforme sur le don de tissus humains est abrogée.

ANNEXE C

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ANNEXE D

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